TO RECEIVE WITNESS TESTIMONY RELATED TO COMMITTEE SUBPOENA

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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TO RECEIVE WITNESS TESTIMONY RELATED TO COMMITTEE SUBPOENA

Wednesday, May 28, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 7:28 p.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Flores, Denham, Runyan, Benishek, Huelskamp, Coffman, Wenstrup, Cook, Walorski, Jolly, Michaud, Brown, Takano, Brownley, Titus, Kirkpatrick, Ruiz, Kuster, O'Rourke, and Walz.

Also present: Representatives Bishop of Georgia and Jackson Lee.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The CHAIRMAN. I want to welcome everybody to our hearing tonight where we're going to discuss VA's continue to lack of compliance with a subpoena for documents that this committee issued on May the 8th.

First, I want to ask unanimous consent that Representative Sheila Jackson Lee from the State of Texas be allowed to join us here on the dais tonight. She said she will be a little bit late, but I'd like to ask unanimous consent for that.

Hearing no objection, so ordered.

As I'm sure many of you are aware, this afternoon, the VA Office of Inspector General issued an interim report that confirmed appointment scheduling manipulation discovered by this committee and substantiated that significant delays in access to care have negatively impacted the quality of care at the Phoenix VA Medical Center.

The OIG also indicated that it has expanded its investigation and has opened cases regarding 42 VA medical centers. The OIG clearly found that inappropriate scheduling practices are systemic throughout the VA. The OIG's interim findings make it all the more urgent for VA to come clean and fully comply with our subpoena. Veterans' health is at stake, and I will not stand for a department cover up.

Further, to fulfill our congressional oversight duties, it is absolutely essential to receive the documents that we have requested from the Department of Veterans Affairs. The scope of the May 8 subpoena was very narrow and was sufficiently tailored to provide reasonable time to produce the documents in full. The subpoena

simply demanded production by May 19 of all emails and written correspondence sent and received by certain VA officials between the 9th of April and the 8th of May regarding the destruction or disappearance of alternate or interim wait list at the Phoenix VA Medical Center.

My staff was told that the committee would only be receiving a partial response on the original due date and that VA would produce additional documents on a rolling basis over an indefinite and undefined period of time thereafter. If this committee were to acquiesce to VA's unilateral rewriting of the subpoena terms, it would perpetuate VA's belief that selective compliance with committee requests is acceptable and would allow VA to continue its perceived mission to prevent this committee from doing its job.

Last night, we received from VA what they purport to be the last of the three sets of documents that they are going to produce for this committee. The VA has claimed that they searched 27 different record custodians and they have produced over 5,500 pages of documents.

At this point, given their pattern of stonewalling committee request, I am not at all convinced that they have conducted a thorough and comprehensive search for responsive records. I know that VA is withholding documents relating to at least three relevant communications by claiming attorney-client privilege.

However, VA failed to produce the privilege log demanded by the subpoena or provide any explanation whatsoever, which is necessary for us to consider whether we will accept the assertion of the privilege. This committee deserves a complete explanation of the interim list document destruction at Phoenix and for its general failure to respond to ongoing requests related to delays in care.

Last week, I invited Ms. Joan Mooney, Dr. Thomas Lynch and Mr. Michael Huff to explain VA's incomplete record production to the committee. They did not come. Dr. Lynch was in Phoenix.

On May 22, we prepared three additional subpoenas for Dr. Lynch, Ms. Mooney and Mr. Huff to compel them to appear before us this week if they again decided to decline our invitation to attend this evening's hearing.

We expect VA to be forthcoming, but unfortunately, it takes repeated requests and threats of compulsion to get VA to bring their people here. I look forward to hearing what they have to say.

I now recognize the ranking member Mr. Michaud for any opening statement he would like to make and then we will proceed with questioning.

[THE PREPARED STATEMENT OF CHAIRMAN JEFF MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF MICHAEL MICHAUD, RANKING MEMBER

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Tonight, we again find ourselves in a very difficult position, and I do appreciate the witnesses appearing before us this evening and for the additional production, push of materials that came overnight. Unfortunately, as you heard from the chairman, those materials and the release of the interim OIG report today did not pro-

vide the answers we sought but rather just raised additional question.

Mr. Chairman, I share your frustration. I share your passion for getting to the bottom of this issue. We have been bipartisan on so many things within this committee, and I'm hopeful that we can continue that, even as this situation gets increasingly difficult and emotionally charged. I'm not completely satisfied with the VA's response to our inquiries in their compliance with the subpoena.

However, I do feel over the past few days that there has been a shift towards increase of responsiveness and offers to try to work harder to satisfy our requirements. A key take-away for me tonight will be hearing the VA response to our requests for information and what the reasonings are to date for failing to do so in a timely manner.

Let me be clear: I am not happy. I'm not wholly satisfied with the VA responses we've received to date. We do expect answers. We'll get to the bottom of this to uncover the truth and ensure a solution is implemented that never allows something like this to happen again. We expect accountability and full accountability for every failure that has harmed a veteran and for every individual who perpetrated such harm. I would strongly urge the IG to diligently but swiftly provide a comprehensive final report so we can take action and hold people accountable.

We all share the same goal of ensuring that our veterans receive the highest quality care and treatment possible; that they deserve nothing less. I believe, as national leaders, we rise above politics and emotion and act pragmatically to achieve the best outcomes for our veterans. We must take our responsibilities seriously and that will yield results. I look forward for an opportunity to get some substantive answers from the VA this evening.

Mr. Chairman, I yield back.

[THE PREPARED STATEMENT OF MICHAEL MICHAUD, RANKING MEMBER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much to the ranking member.

Prior to beginning our questions this evening, I'd like to ask unanimous consent that the ranking member, Mr. Michaud, and myself be allowed to have 15 minutes each for questioning followed by 5 minutes for members, and if necessary, we will have a second round of questioning, as well.

Hearing no objection, so ordered.

Dr. Lynch, Ms. Mooney, Mr. Huff, thank you for attending. If you would, please stand and raise your right hand.

[Witnesses sworn.]

The CHAIRMAN. Dr. Lynch, just today the VA Office of Inspector General issued an interim report identifying multiple lists other than electronic waiting list and multiple types of scheduling practices that are not in compliance with VHA policy. When you went to Phoenix after the hearing in this committee on April 9, did you identify these same issues during your review, or did you just merely take the word of those in charge that everything was fine?

Dr. LYNCH. Mr. Chairman, I have made——

The CHAIRMAN. If you could turn the mike on please, sir.

Dr. LYNCH. Sorry. Mr. Chairman, I have made three visits to Phoenix to date. The first visit, the visit after which I reviewed my

findings with your committee staffers, was an initial visit. We had little information to go on at the time. We did identify, and I did share with your committee staffers that we thought we had identified an intermediate work product that was used to identify veteran appointments that had been canceled for the purpose of rescheduling those veterans.

I also indicated at that time that it was my impression that document had been appropriately destroyed when its purpose was over, when the veterans had been rescheduled. I also made it very clear to the committee staffers that this was an iterative process, and that we were going to continue our review. I returned about a week and-a-half later with two additional staff, a scheduling expert and an individual with expertise in systems redesign and scheduling. We spent a week at the Phoenix VA dissecting and understanding the process of scheduling that had been going on since late 2012. I will be happy to outline that process for you.

Beginning in November of two thousand—beginning actually in October of 2012, the facility committed to identifying veterans who had been scheduled more than 3 months in the future. They identified more appropriate slots to see these individuals sooner.

The CHAIRMAN. Okay, Dr. Lynch, I apologize, but we're not going to be able to have longwinded comments. You said you told the staff that it was your impression that the list was destroyed. Is that what you're saying today?

Dr. LYNCH. That is what I'm saying.

The CHAIRMAN. Okay. Mr. Huff——

Dr. LYNCH. At that time.

The CHAIRMAN. Mr. Huff, you were in the room at the time——

Mr. HUFF. I was.

The CHAIRMAN. Did Mr. Lynch say it was his impression that the list was destroyed? You are under oath.

Mr. HUFF. I believe that's what it—what he said.

The CHAIRMAN. You believe or you know?

Mr. HUFF. I believe that's what he said, from my memory.

The CHAIRMAN. You didn't take any notes? You were in the room and you took no notes?

Mr. HUFF. I took notes, and I don't have those in front of me today, but I believe——

The CHAIRMAN. Let me ask you a question. If you took notes at that meeting, why haven't those notes been provided to this committee as part of the subpoena for all records talking about the destruction of the list, including notes, phone calls, emails, letters and memos?

Mr. HUFF. I turned over all of my documents to the Office of General Counsel.

The CHAIRMAN. Does anybody at the table know why those notes have not been delivered? Ms. Mooney.

Ms. MOONEY. The Office of General Counsel——

The CHAIRMAN. Your mike is not on.

Ms. MOONEY. Oh, sorry. Because this is a legal issue, the Office of General Counsel has the lead for the Department. My understanding is that upon receipt of the subpoena on May 8, they began—the Office of General Counsel began responding to the subpoena and dedicated a significant number of employees and re-

sources to that effort in pulling responsive email records for 27 individuals.

The CHAIRMAN. Let me——

Ms. MOONEY. I also——

The CHAIRMAN. Excuse me. Let me interrupt you and read you the definition in the subpoena. The term "document" means any written record or graphic matter of any nature whatsoever regardless of how recorded, whether classified or unclassified and whether original or a copy, including but not limited to the following: Memoranda, instructions, working papers, records, notes, letters, notices, confirmation, telegrams; in other words, everything.

Why have we not received all of the documents requested in the subpoena, even though we got a letter from the general counsel late last night that said VA was done?

Ms. MOONEY. I understand the general counsel has held a very small number of documents for attorney-client privilege. They've been in communication with your staff in ongoing discussions related to those documents.

The CHAIRMAN. Are the records from a briefing part of the protected notes that the general counsel is claiming attorney-client privilege about?

Ms. MOONEY. Mr. Chairman, I would defer to the Office of General Counsel for that.

The CHAIRMAN. So the question again is, has VA complied with the terms of the subpoena?

Ms. MOONEY. It's my understanding that VA has provided the committee with relevant information in response to that subpoena.

The CHAIRMAN. Can you say anything without reading your prepared notes?

Ms. MOONEY. Sir, this is within the Office of General Counsel. General counsel would be the appropriate party to ask.

The CHAIRMAN. And we did ask the Office of General Counsel to come brief Members last week, and the general counsel declined. He said he declined because he didn't want to brief the Members. He wanted to brief the staff. There's not a single person sitting up here in this room that's staff that voted for the subpoena. The Members did. Until VA understands that we're deadly serious, you can expect us to be over your shoulder every single day.

And while I have your attention, can you please explain to me why we, in fact, have 110 outstanding requests for information, some dealing with this issue specifically, and if you want a specific one, why have you not told this committee yet who was disciplined in Augusta, Georgia, and Columbia, South Carolina, where nine veterans died because they were on a waiting list for colonoscopies?

Ms. MOONEY. As you know, Mr. Chairman, in the last 5 years, the Office of Congressional Legislative Affairs has responded to over 100,000 requests for information.

The CHAIRMAN. Ma'am, ma'am, ma'am, ma'am, veterans died. Get us the answers, please.

Ms. MOONEY. I understand that, Mr. Chairman. And I will look——

The CHAIRMAN. That's what you said 3 months ago. This has been going on since January. Since January. In case you don't know it, we put on our Web site every week what we ask for and

nothing changes from week to week. We have an oversight responsibility in this Congress, and we cannot do our job appropriately if you don't provide us the information that we request.

Dr. Lynch, given the fact that you declared the issue a misunderstanding in the first brief, as staff has related it to me, and the Office of Inspector General's report issued today substantiated inappropriate scheduling and said it was systemic throughout VHA, do you believe that you have the credibility now necessary to identify and fix the problems?

Dr. LYNCH. Mr. Chairman, I believe I used the term "misunderstanding" with respect to the references that were being made to a secret list. I did not make any qualifications or statements as to whether I thought the actions occurring in Phoenix were appropriate.

The CHAIRMAN. So is your contention that there still was no secret list?

Dr. LYNCH. It is my contention that there were a number of documents, three of which were identified by the IG today, one of which we identified earlier that were working documents used to provide information about patients for addition to the waiting list or for rescheduling of patients. I did not think they were secret lists. I think they could easily have been misunderstood as being secret lists.

The CHAIRMAN. I would remind the committee that we discussed this last week, as well. Dr. Lynch came back from Phoenix and asked to brief the four corners, of which, in just a matter of hours, we were able to have the four corners come together of the staff, and in that, you said, and I'd like to know what gave you the impression that the list had been destroyed.

Dr. LYNCH. It had been conveyed to me secondhand by one of the members who had been with us on the first visit that the center was using a document to record the names of veterans who had been canceled, whose appointments had been canceled so that they could be rescheduled. After the patients and veterans had been rescheduled, the list was no longer required, and it was destroyed. It did contain patient-identifiable information.

The CHAIRMAN. Okay. Staff is telling me that it was described to them as a transitional document as people were transitioning from paper over to the electronic waiting list. And I guess my question is, was the list destroyed before or after this committee requested a preservation order for all documents?

Dr. LYNCH. Mr. Chairman, it was my impression that those lists were destroyed before your preservation order. I was trying to explain, before you asked me to be brief, that this was occurring between October and November of 2012 and mid-2013. At the time of my first visit, we thought that the transfer was occurring to the electronic wait list.

We learned during the course of the second visit that the transfer and the use of this document was occurring during the course of rescheduling patients because they were trying to provide care more promptly and because they were trying to consolidate clinic profiles to make the clinic management more efficient.

So, in that process, patient appointments were being canceled, the VistA scheduling system that VA uses automatically generates

the list of patients who are canceled so that list can be used to reschedule patients. Once the rescheduling has occurred, the list is no longer necessary. So it is appropriately destroyed as it does contain patient-identifiable information. And it was my understanding, Mr. Chairman, that this did occur from late 2012 through mid-2013.

The CHAIRMAN. Why didn't we know that when we first asked about it?

Dr. LYNCH. Because I had only come back from the first visit. It wasn't until we took back the team and spent a week there working through the entire process that we understood exactly what had been going on, Mr. Chairman.

The CHAIRMAN. I have written a letter asking for that specific information—and has it been responded to? Okay—and it was never responded to, hence the subpoena. So, again, we are trying to get answers. Nobody is giving the answers to us. That is why we are here tonight.

Let me real quick, before my time runs out, according to an internal VA email received under the subpoena, an employee in Los Angeles reported up the chain of command that wait times in the Los Angeles VA Medical Center was, in fact, being manipulated. Interestingly, the director of the facility's response was, the employee was simply a disgruntled employee.

In a related email, a senior official substantiated, and I quote, "There appears to be inappropriate actions by the supervisor in Los Angeles," end quote. Would you comment for the committee's behalf what's going on in Los Angeles?

Dr. LYNCH. Mr. Chairman, the only concerns that I am aware of that related to Greater Los Angeles were concerns expressed by an employee regarding the cancellation of radiology orders which were felt to be stale, old and no longer appropriate. It is my understanding based on discussions with the chief of staff as well as the chief of radiology that this was done after a careful review of those orders and the physicians were notified at the time of cancellation in case they needed to reschedule that appointment or request.

The CHAIRMAN. So every single veteran was contacted who had one of their orders canceled?

Dr. LYNCH. That is what I was told, Mr. Chairman.

The CHAIRMAN. Well, let me give you a little hint: VA won't tell you the truth.

Dr. LYNCH. Mr. Chairman——

The CHAIRMAN. So if you're relying solely on the management of these facilities to tell you the truth, you're not going to get it. You're just not going to get it. The complaint, by the way, before my time runs out, very quickly, is not in radiology. It's exactly what we're seeing all over the country, so I would suspect that you better have somebody go to Los Angeles quickly before they start destroying secret lists.

Mr. MICHAUD.

Dr. LYNCH. Mr. Chairman, if you share the documentation with me, I will be happy to follow up. I think you know my commitment to veterans and my commitment to understanding problems with their VA health care system.

The CHAIRMAN. Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Dr. Lynch, on what date did you first become aware that there were allegations of problems in Phoenix?

Dr. LYNCH. On April 9, 2014, Congressman.

Mr. MICHAUD. On what date did you travel to Phoenix to investigate?

Dr. LYNCH. I made the first visit to Phoenix, I believe, on April 17. It was the Thursday before Easter. I was there through Easter until Tuesday of the following week.

Mr. MICHAUD. And was that the day—what was the date you returned back to DC.?

Dr. LYNCH. I believe it was on April 23, and I believe I came down to discuss the initial findings with the committee staff on April 24.

Mr. MICHAUD. And under whose direction did you fly to Phoenix?

Dr. LYNCH. Dr. Robert Petzel had asked me to go to Phoenix.

Mr. MICHAUD. And who did you travel to Phoenix with?

Dr. LYNCH. Myself; my wife joined me for the weekend.

Mr. MICHAUD. Can you please explain your role in the initial investigation in Phoenix as well as the role of the individuals that you are with.

Dr. LYNCH. My initial role in Phoenix was to try to get an understanding of what had happened, to get a sense for how the congressional delegations as well as the veterans' service organizations were viewing the allegations. I brought with me two individuals, Dr. Mike Davies and a scheduling expert, who did some initial work in discussing scheduling processes in Phoenix.

I focused my attention on working with the Quality Assurance Department to identify what they had—what information they had about deaths that had occurred at the facility and what review process they had put in place to look at those deaths. We further put in place a process to match those deaths against potential delays in care so we could see whether or not any of the deaths they had records of, were related to delays in care.

Mr. MICHAUD. You said you talked with Mike Davies. He didn't go down with you?

Dr. LYNCH. Mike Davies did go down with me along with his scheduler. They spent their time talking with the folks in the scheduling office, also with providers to get an understanding of their clinic management model.

Mr. MICHAUD. Okay. Because I thought you answered my question when I asked you who did you travel to Phoenix with. I thought you said by yourself.

Dr. LYNCH. Oh, I'm sorry. I flew by my myself. They joined me there the Monday following Easter.

Mr. MICHAUD. Okay. Thank you for that clarification.

And when did you first become aware that the Phoenix facility had used an Excel spreadsheet in regards to patients' scheduling?

Dr. LYNCH. Dr. Davies had indicated to me that they had heard there had been use of an Excel spreadsheet to transfer information about canceled patients to allow rescheduling of those patients. I will say that, subsequently, we found that spreadsheet reference to be incorrect when we went back the second week and worked through the process more completely.

Mr. MICHAUD. And what date was that on?

Dr. LYNCH. The second visit occurred during the week of May 5 through May 9. I arrived on Monday, May 5. I left on Saturday, May 10.

Mr. MICHAUD. And during what period of time was the spreadsheet used?

Dr. LYNCH. I would correct the statement. I no longer think it was a spreadsheet. We now believe that it was an intermediate product generated by the VistA system. When you cancel a patient it generates a document that says these are the patients you canceled. It provides information about their Social Security number, the date of their appointment and the time of their appointment so that you can use that information to reschedule the patients.

Mr. MICHAUD. And the date that Mr. Davies informed you of the spreadsheet or—I guess you don't call it the spreadsheet. What was the date that you first——

Dr. LYNCH. At the time, we thought it was.

Mr. MICHAUD. Okay.

Dr. LYNCH. As I stressed to the committee staffers, this was an iterative process. We were learning. We wanted to be sure we understood the process. I believe he informed me on either April 21 or April 22.

Mr. MICHAUD. And you informed the committee staff that this spreadsheet, so-called spreadsheet, was destroyed at some point. When was it destroyed and who authorized it?

Dr. LYNCH. My understanding was that it was destroyed when the patients had been rescheduled, which would have been probably in late 2012 through mid-2013.

Mr. MICHAUD. Okay. And it's my understanding that a paper wait list may constitute a number of items, including spreadsheets, Word documents and Post-it notes. During your investigation in Phoenix, did you become aware of any other item that may be loosely considered a paper wait list being use in the Phoenix?

Dr. LYNCH. During the course of our second week there, my second week there, we did identify three additional documents. They were also referenced by the inspector general's report today. They were, first, the NEAR list. Second, a the request to schedule a consult which was generated from the emergency department, and finally, the requests to schedule that were generated from the VA Phoenix's help line when patients called in asking for an appointment.

Mr. MICHAUD. And who authorized the destruction of the list?

Dr. LYNCH. I'm not sure, sir, who authorized the destruction. I think it was felt that once the purpose of the list or the document had been completed, the patient's entry had been added on to the electronic wait list or the patient had been scheduled, that it was appropriate to destroy the document because it contained patient-identifiable information and could potentially have adverse consequences if it was not destroyed.

Mr. MICHAUD. And who—was it the visiting director that, or I mean, is that a common policy that it be destroyed or——

Dr. LYNCH. To my understanding, Congressman, it's a Federal mandate that we cannot keep lists of personally-identifiable information once they have served their useful purpose.

Mr. MICHAUD. Okay. If you identified other items used as a paper wait list, what were they and when were they used?

Dr. LYNCH. So the only four documents that I identified were the intermediate work product generated by VistA, the VA's electronic health record, that documented the names and Social Security numbers of patients whose appointments were canceled; were the NEAR list, which is actually, to my knowledge, an electronic document that is generated by VA in response to new enrollee requests for appointment; the documents used to store requests for consults from the emergency department and the documents used to transfer information about patients requesting appointments when they called to the VA hot line.

Mr. MICHAUD. Okay. And going back to when you first became aware of the problems with Phoenix, can you please detail what steps were taken at the central office to investigate and respond to these allegations?

Dr. LYNCH. The steps, sir, included the following: Number one, I was asked to go back so that we could develop an understanding of what scheduling processes were going on. At the same time, during the week of the 5th, a second team arrived from VA central office. Their focus was to take the information that we had gathered, develop recommendations and provide those to the facilities and to the scheduling office to improve their efficiency.

The week after I left, there was a third team that arrived, experts in systems redesign who were working with the clinic to look at their processes and assure that the clinic was functioning in an efficient fashion so that we were not using—we were not missing valuable resources that could be used to provide care to veterans.

Mr. MICHAUD. And who was part of the second team?

Dr. LYNCH. Congressman, I do not recall at this time. The names have slipped from my mind.

Mr. MICHAUD. But who was initially in charge of the VA's response?

Dr. LYNCH. The VA's response was led by me while I was in Phoenix and by Mr. Philip Matkovsky, who was putting together the supporting documentation in Washington that the teams were using to improve the processes in place.

Mr. MICHAUD. Okay. And if working groups were formed to address the allegations in Phoenix, under whose authority were they formed and on what date?

Dr. LYNCH. I cannot tell you under whose authority they were formed. The process began to come into play probably late in the first week of May as we began to develop a way forward.

Mr. MICHAUD. Okay. What was your initial assignment when you first were asked to go to Phoenix?

Dr. LYNCH. My initial assignment was to go down and, try to understand what was going on, try to understand the climate that was present within the organization and also try to identify what information they did have about deaths that may have occurred in their facility.

Mr. MICHAUD. And are you surprised by the findings in the interim report released today by the IG?

Dr. LYNCH. Not at all. In fact, I would emphasize that I did contact the IG when I returned to Washington. I shared the informa-

tion that we found with them. So it does not surprise me what they reported. We had shared that information with the IG.

Mr. MICHAUD. So nothing in there was a surprise, then?

Dr. LYNCH. I think we had not looked at the numbers of patients that were on those lists. That was a surprise. But everything else we had identified during the course of our visit.

Mr. MICHAUD. Okay. Thank you.

Ms. Mooney, in looking at the documents the VA has produced in response to the committee's subpoena, are you aware if the response includes any documents or emails dated prior to April 24, 2014?

Ms. MOONEY. Congressman Michaud, the subpoena was responded to by the Office of General Counsel as it's a legal action.

Mr. MICHAUD. So you're not——

Ms. MOONEY. So I don't have them. I don't have them. I wouldn't have knowledge of that.

Mr. MICHAUD. Okay. Can you please explain the difficulties that the two face answering the questions posed by the committee of, you know, weeks ago?

Ms. MOONEY. I think in terms of weeks ago with regard to——

Mr. MICHAUD. Well, when was the spreadsheet, you know, that was mentioned by Dr. Lynch at a briefing on April 24 destroyed?

Ms. MOONEY. Oh, yes. Dr. Lynch didn't provide a response to the committee's May 1 letter regarding his statement at the April 24 staff briefing because the Office of Inspector General's investigation was ongoing as well as his own investigation was ongoing. And at that time, my understanding is, there were no facts upon which to respond to the committee's request in the letter. So my understanding is we stuck to the facts in the letter.

Mr. MICHAUD. But is this unique to the VA? I mean, when you talk about the, you know, your attorneys, are these technical difficulties common among all agencies or just specific to the VA?

Ms. MOONEY. Technical difficulties, I'm not sure.

Mr. MICHAUD. Well, the concern that I have is the fact that the committee asked for very basic questions, very narrow questions so it would not interfere with the inspector general's report. And we thought it was something we should be able to get without any problems, but there seems to be an ongoing delay in getting information to the committee.

And any time we asked about certain information, the standard response is, Well, we can't give that because of our legal counsel. And that's a concern that I have is the fact that what appears to be unresponsiveness from the Department for very basic questions that we originally asked before we issued the subpoena.

Ms. MOONEY. In the case of this subpoena, we had a number of staff in the Office of General Counsel, I know, who worked 2 and a half weeks to provide the documents in response on a rolling basis.

Mr. MICHAUD. Well, why didn't you tell us about the IG investigation and that no facts, instead of just, you know, ignoring us? I mean, if the IG was doing an investigation, why didn't you tell us initially, and therefore, you could not respond?

Ms. MOONEY. I believe, my recollection would be that, I think that as of the April 24 briefing, I believe we knew that the IG was in. I'm not sure.

Dr. LYNCH. The inspector general was in Arizona at the same time we were there. We did talk with them to assure that we were not in their way.

Ms. MOONEY. Yes.

The CHAIRMAN. Thank you, Mr. Michaud.

Mr. Lamborn for 5 minutes.

Mr. LAMBORN. Thank you, Mr. Chairman.

Before I question the witnesses, I first must call for the resignation of Secretary Shinseki. I was waiting for information to be gathered to make my judgment and now it is in. Based on the interim inspector general report that came out today, our veterans in Phoenix, and maybe other cities, have not been treated properly.

This report states, quote, Our review at a growing number of VA medical facilities have confirmed that inappropriate scheduling practices are systemic throughout VHA. The tragic possibility that veterans who have died while on the waiting list have died because of the waiting list is still open. The OIG will hopefully answer this in their final report, though not in this interim report.

Even if the Secretary did not know in advance of these wrongdoings, and I don't believe he did, these violations should not have happened on his watch. I believe that Secretary Shinseki's service while in Active Duty was honorable, but success in the military does not automatically translate into success in the policy and political realms.

Here we have a concrete example of the failure of bureaucracy and a failure of leadership. Funding has not been the issue. A supportive nation has not been the issue. The issue is hands-off leadership. Even the Secretary's response to the IG investigation today was a failure. He promises to triage the 1,700 veterans on the secret waiting list in Phoenix. These 1,700 veterans should not be triaged; they should be seen immediately.

Dr. Lynch, 1,700 veterans are on a secret waiting list in Phoenix with average wait times of 4 months for a primary care visit. We know of similar stories emerging elsewhere. Why are thousands of veterans waiting months for care at the VA when there is a system already in place to treat these men and women in the private sector using fee basis? If the care is not available at the VA, they can go to any private hospital or clinic and get immediate care. Why isn't that being done?

Dr. LYNCH. Congressman, that is being done. There are plans in place to contact every one of those 1,700 veterans by close of business on Friday. Their need for care will be assessed, and they will be offered fee basis services if appropriate. Across VHA, there is also a process in place which began approximately a week or so ago, and that process is asking each of the facilities to look at their wait lists to identify those patients who are waiting for care, to contact those veterans and to offer them fee basis services if that's what they request.

Mr. LAMBORN. And I'm glad you did not say that you're waiting for more money from Congress. The money has been given to you. The money is there. In fact, money has carried over each of the last

5 years, from 2010 to 2011, $1.5 billion was carried over; $1.1 billion from 2011 to 2001. Even this year we anticipate half a billion being carried over. So money is not the issue. You would agree with me on that?

Dr. LYNCH. Congressman, care is the issue. And we need to assure that if veterans have been waiting, that we identify those veterans and we provide care in the community if necessary.

Mr. LAMBORN. Okay. Well, I would view this as a type of disaster relief that veterans are entitled to and the money is there.

Ms. Mooney, let me ask you this: I recently spoke with the directors of VA health care facilities in Colorado and asked them about whether there are waiting lists in Colorado. They assured me that there was not, to their knowledge, but when the information comes out in a report like this that there are systemic problems throughout the country, we have problems getting the documents that we want. Trust has eroded. What can we say to veterans to restore that trust? I think we have a real problem with broken trust.

Ms. MOONEY. Congressman, we appear this evening in good faith to answer the best course of action is the one that best serves the needs of our veterans. We pledge to work with you to get you what you need.

Mr. LAMBORN. Thank you, Mr. Chairman.

I yield back.

The CHAIRMAN. Thank you very much.

Ms. Brown, you're recognized for 5 minutes.

Ms. BROWN. Thank you, Mr. Chairman.

OPENING STATEMENT OF HON. CORRINE BROWN

You know, I've been on this committee for 22 years, and first of all, before I begin, I am going to put in the record a letter that I am sending to the Governor of the State of Florida. He is grandstanding, indicating that he is suing the VA for the fact that he is sending people to the various VA facilities around the State of Florida, and he wants to take a look at the records.

Now, you know this is the most grandstanding action I've seen since I've been in Congress, because first of all, the State has absolutely nothing to do with the VA. And in fact, we have got over 4 million people that need health care expansion that Florida are sending back that's could die because they're not getting the quality health care that they need. That's the first thing.

So can you, Ms. Mooney, tell me anything about the lawsuit of whether or not the Governor has sent people, Governor Rick Scott, to the various VA facilities throughout Florida? I've never even heard of anything like that, and I am certain it has never happened in the history of the United States of America.

Ms. MOONEY. Congresswoman Brown, I'm not—I have not heard of anything like that before these incidents, and I would be happy to take your request to our Office of General Counsel and Intergovernmental Affairs that deals with our State partners.

Ms. BROWN. That's what it is: State partners. And speaking of State partners, I personally went to California and I came back and reported to this committee that we had 400 units that we had built that was standing still for 2 years and no veteran was in these brand new facilities. 400 units in L.A. on the property. So

we're not talking about problems that just started recently at VA. It's been problems for years.

In fact, I want to commend the Secretary, because let's be clear, Vietnam veterans, they were getting the runaround, the runaround from the VA system. This Secretary opened it up and brought in millions of additional veterans. Millions. And yes, we have a responsibility to make sure that they're taken care of.

But I did my reconnaissance in Florida, and I can tell you, we're doing fine in Florida. We have a new hospital in Orlando soon, I hope. I've been working on it. We have a wraparound in Gainesville. We have new cemeteries in Florida. We serve over almost 600,000 veterans a year in Florida. So I can truly say, I went and talked to various VA groups in Florida and not one single complaint, because we are doing our job and that is what this committee is supposed to do, make sure that the VA is doing what we committed to the other veterans.

And let's forget the grandstanding, because I've seen a lot of it, but I was here. Yes, we do have money for the veterans, but for years, it was just a talk. It was just a talk. But under this President, and when we had a Democratic House and a Democratic Senate, we got the largest VA increase in the budget in the history of the United States. So we do have the money, but we've got to know that we are not just talking the talk; we are walking the walk.

Now, Dr. Lynch, is there any additional information that you want to give me about the overall problems with the VA around the country? Because I know Florida is not included.

Dr. LYNCH. Thank you, Congresswoman.

I want to make sure that I choose my words carefully. I've thought about this for a long time. Let me begin by saying, I think that it is absolutely critical that VA maintains focus on its mission to serve veterans and its core business to provide for primary health care for our veterans. I think it's important to remember that we have a good system. I think that system is worth saving. The quality of health care does compare favorably with that in the private sector.

In the last 5 years, we have provided health care to over 200—or over 2 million new veterans. Our performance measures, however, have become our goals, not tools to help us understand where we needed to invest resources. We believed our access numbers, but we undermined the integrity of our data when we elevated our performance measures to goals. We were told that the scheduling system was challenged, but we discounted the OIG reports and patient concerns as exceptions not the rule.

We could have and should have challenged those assumptions. This was an insidious process. It was not obviously apparent while it was happening. I think, however, having said that, that there is a way forward. I think we must first charge our medical center directors and network directors to assess and insure the integrity of their organizations. This has to be the first step. With integrity we do have the tools to monitor demand and capacity and to assign resources appropriately. We will also need to assure a collaborative relationship with Congress. This will be essential.

VA has faced criticism in the past, and it is better for it. In the 1940s, Omar Bradley and Paul Hawley remodelled the VA system,

involved our academic medical partners and established a research presence in VA. In the mid-1980s, there were questions about the quality of VA surgical care. In response, the VA developed a risk-adjusted care model that has been adopted by the private sector and is now used to assess surgical mortality across the country.

In the mid-1990s, there again were concerns about VA care. VA implemented a new model of care emphasizing outpatient care and began to implement the use of the electronic health record, which is now used by health care across this country. We have a good health care system. We have a good foundation. We have challenges. I recognize that. I think, working together, we can solve those challenges, and we can once again provide evidence of an excellent health care system for our veterans.

Ms. BROWN. Thank you, Mr. Chairman, for the additional time.

[THE PREPARED STATEMENT OF HON. CORRINE BROWN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Lynch.

And also Ms. Brown, would you please give me the document that you wanted, and I'll ask unanimous consent that it be entered into the record.

Without objection.

The CHAIRMAN. I'll also ask that unanimous consent that Mr. Bishop from Georgia be allowed to join us at the dais.

Without objection, so ordered.

The CHAIRMAN. Mr. Bilirakis for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it. Thank you for holding this hearing.

I want to thank the ranking member, as well.

Thank you both for your strong leadership in this area.

I'm going to run right into the—I'm going to jump right into the questioning in the interest of time instead of making a statement.

Dr. Lynch, in correspondence sent to our committee on May 7, 2014, Secretary Shinseki confirmed your statement that the interim wait list was maintained and destroyed, which you told the House and Senate committee staff on April 24, 2014. Is that correct?

Dr. LYNCH. That is my understanding, Congressman.

Mr. BILIRAKIS. How and when did you become aware of the interim wait list referenced in this hearing?

Dr. LYNCH. I first became aware of the reference, and I would correct the concept that this was an interim wait list. This was a work product generated by the VistA scheduling system that, when patients were canceled, was generated so that we were aware of who was canceled so that those patients could be rescheduled. It was not a wait list. It was an interim work product.

Mr. BILIRAKIS. Okay. Dr. Lynch, what is VA's current policy concerning its document retention period, specifically regarding electronic patient records under VHA's records control schedule guidelines? Do you know of the policy, the current policy, sir?

Dr. LYNCH. Congressman, I don't have the policy available.

Mr. BILIRAKIS. Under the Veterans Health Administration directive, 6,300 is States. Disposal authority is the legal authorization obtained from the Archivist of the United States, the National Ar-

chives and Records Administration, for the disposal of records and recorded information.

Next question for the entire panel: What was the reasoning for the destruction of said documents? I'd like to hear from the panel.

Dr. LYNCH. I'll start, Congressman.

Mr. BILIRAKIS. Please.

Dr. LYNCH. It was my understanding that they were intermediate work products; that they had patient-identifiable information; and that when their usefulness had been served, it was appropriate to dispose of them.

Mr. BILIRAKIS. Yes, please.

Ms. MOONEY. I have not been involved in the investigation nor was I present at the staff briefing.

Mr. BILIRAKIS. Sir, what was the reasoning for the destruction of documents?

Mr. HUFF. I defer to Dr. Lynch.

Mr. BILIRAKIS. Why was the interim list not considered a system of record and maintained, Doctor?

Dr. LYNCH. I'm not sure I can answer that completely, Congressman. I think because records of patient cancellation are preserved in the overall record system, this was used as a process to assure that we knew who was canceled so they could get rescheduled.

Mr. BILIRAKIS. When were these documents destroyed, Dr. Lynch?

Dr. LYNCH. To the best of my knowledge, they were destroyed sometime between late 2012 and mid-2013.

Mr. BILIRAKIS. Did anyone from the VA or a third party conduct some form of verification prior to the list's destruction?

Dr. LYNCH. I don't have knowledge of that, Congressman.

Mr. BILIRAKIS. How long was the interim list in existence, and are there any other documents currently in use just like this? Are you aware of any documents currently in use just like this, quote-unquote, interim list?

Dr. LYNCH. To my knowledge, there were lists that were used to transfer requests for care from the emergency department as well as requests for care from the VA help line. I believe they were referenced in the IG report. I believe that the IG also referenced that they were destroyed when the information had been entered into the electronic wait list.

Mr. BILIRAKIS. The next question. Who within the VA is responsible for the management and maintenance of VA's policies for record retention? Does anyone on the panel know?

Dr. LYNCH. Congressman, I don't know. We'll have to take that for the record.

Mr. BILIRAKIS. Anyone else on the panel know? Can you please get back to me?

Do you believe, whoever it might be, whether it's he, she, or they, should be held accountable and penalized under VHA's own records controlling scheduling guidelines if found to have destroyed records without prior authorization? Who can answer that question for me? Doctor? Should they be held accountable?

Dr. LYNCH. Congressman, I don't think that we're in a position to answer that question.

Mr. BILIRAKIS. Anyone else on the panel? Okay.

Thank you very much, Mr. Chairman. I appreciate it. I yield back.

The CHAIRMAN. Thank you.

Mr. Takano, you're recognized for 5 minutes.

Mr. TAKANO. Thank you, Mr. Chairman.

You know, the VA is a huge and complex organization of many, many facilities, and when such a bureaucracy is under siege, people often run for cover. I recall an instance in post-Apartheid South Africa, when they were looking for accountability, that there was something called a truth commission to encourage people to tell the truth.

I was reminded of this somewhat by this New York Times op-ed piece by Dr. Sam Foote, the retired VA physician who blew the whistle in the Phoenix VA Medical Center. And he suggested an alternative to Secretary Shinseki's approach to the internal audits. I mean, he's skeptical that they're going to work and produce good data.

He believes that the Government Accountability Office should conduct an anonymous survey of primary care providers and other health professionals at VA hospitals and clinics to find out what they think the real new and returning patient waiting times are. Then she should give the hospital administrators a 1-week amnesty period to report their own version of the waiting times, and if the numbers match, then you have reliable data. If they don't, then send the inspector general out to audit them. If the hospital administrators have manipulated their data, then appropriate action will be taken.

What do you think about this sort of approach as a way to try to get at reliable and accurate data?

Dr. LYNCH. Congressman, I think I state the obvious when I say that VA needs to work hard to reestablish trust and confidence among veterans.

I think we welcome help from any government agency in identifying problems and helping us come to solution. Whether that is the best option, I don't know, but we have certainly valued the reports from the GAO and the OIG in the past.

Mr. TAKANO. Ms. Mooney and Mr. Huff, could you comment?

Ms. MOONEY. Thank you. We value collaboration in working to provide our veterans the best care.

Mr. TAKANO. Mr. Huff.

Mr. HUFF. I work hard every day to, you know, do my job and provide the information that the committee needs.

Mr. TAKANO. Well——

Mr. HUFF. And I will continue to do so.

Mr. TAKANO [continuing]. You know, I took note of this just mainly because it was the whistleblower himself who suggested that we try another approach, in terms of trying to get accurate information from VA employees.

Is Congress going to get a list from the VA of what other facilities have used, scheduling practices similar to those at the Phoenix VA hospital? I, for one, would like to know if my own VA hospital, the one that serves my area, is using the same practices.

Dr. LYNCH. I believe VA is conducting a nationwide audit. I don't believe that there is any intention not to share that with Congress when it is completed.

Mr. TAKANO. Well, I appreciate that. And, again, this audit is the very issue that I'm sort of raising, about how do we get a good audit.

And, Mr. Chairman, that concludes my questioning. I yield back.

The CHAIRMAN. Thank you.

Dr. Roe, you're recognized for 5 minutes.

Mr. ROE. Thank you, Chairman and Ranking Member.

I'm a medical—I've served at a medical battalion. I'm a veteran, a physician, and I trained at a VA. So I've had—some of my training was at a VA. And it's disturbing to me right now that we've created this uncertainty among our veterans in the country. I think we've lost a lot of trust in this country.

And I want to ask, do you, Dr. Lynch, agree with the interim report that the IG just produced that we have today? Do you agree with the findings?

Dr. LYNCH. Congressman, I do.

Mr. ROE. Okay. You agree with those.

And then we have a situation where you say 1,700 veterans now are going to get care. Why in the world do we have to have hearing after hearing after hearing? I mean, we've done this now at—now we're here on a Wednesday night, having a hearing now that 1,700 veterans—why wasn't this just done?

And what I want—let me just read this to you right here. The length of time these 1,700 veterans wait for appointments prior to being scheduled or added to the electronic waiting list will never be captured in any VA wait-time data because the Phoenix HCS staff had not yet scheduled their appointment or added them to the electronic waiting list. It's the ultimate catch-22.

And let me also ask you, here are people out here—and this is, I think, what troubles me the most. Look, I get being overworked, having more work than you can do, patients than you can take care of. I got that. I understand that completely.

What I do not understand is creating a list right here that have people waiting until they can get on another list to show that they can get an appointment in the time that you—the metrics the VA put up, and then someone gets a bonus, benefits, when veterans are suffering.

Is that what happened? I think it is.

Dr. LYNCH. Congressman, as I mentioned earlier——

Mr. ROE. Is that what happened? I mean——

Dr. LYNCH. I think we elevated a performance measure to a goal. I think people lost sight of the real goal of VA, which is treating veterans. They began to focus on achieving a 14-day—achieving care within 14 days.

Mr. ROE. I agree with you.

Would you say that those particular goals right there that the VA set up—and then, obviously, you had people playing games with it—hurt veterans?

Dr. LYNCH. Congressman, they were flawed measures that became goals——

Mr. ROE. Well, do you think——

Dr. LYNCH.—and it should not have happened.

Mr. ROE. It should not have happened. Do you think it's happening around the country in other VA centers now? Are other people being——

Dr. LYNCH. I think the evidence—I think the evidence from the IG report suggests that this could be a systemic problem. We need to focus, and we need to get the veterans seen in timely fashion.

Mr. ROE. What I don't understand is, as a veteran, as a doctor, as a practitioner, how you can stand in a mirror and look at yourself in the mirror and shave in the morning and not throw up, knowing that you've got people out there—and I can't go to the VA. I make too much money. I'm perfectly okay with that. I have good insurance.

But how in the world—I see some of these people out there. They live in my communities. And they can't get in, and they're desperate to get in. And someone who's making $180,000 a year gets a bonus for not taking care of the veterans. I don't get that.

Dr. LYNCH. Congressman, what's happened is unacceptable. But I have to go beyond that, because I have to figure out how to fix the system. And that's my goal and purpose, is to understand the problem and assure that it doesn't happen again.

Mr. ROE. Well, I certainly, Dr. Lynch, thank you for that.

The next question I have is to the panel, and it's not necessarily you I'm directing it. Why would any information we ask for be withheld? Because that also creates an uncertainty among us here. If you don't give us the information, I'm thinking, well, there's something they're trying to hide.

Why wouldn't you just turn over the documents and they are what they are, just tell the truth? Is there a reason? I mean, I can't—for the life of me, I can't understand why there wouldn't be one thing that the chairman and the ranking member ask for that they don't have right in front of them right now.

Ms. MOONEY. Congressman——

Mr. ROE. Because, in my mind, I'm thinking right now they're hiding something from me, and I have no reason to believe you're not.

Ms. MOONEY. Congressman, our goal—our goal is to be open and transparent and provide as much——

Mr. ROE. That's not, when the documents are not coming in—Ms. Moody, excuse me. Respectfully, if that were the goal, the chairman would have all the documents he asked for.

Ms. MOONEY. Respectfully, sir, the Office of General Counsel responded to the subpoena in accordance with the subpoenaed documents.

Mr. ROE. I don't—well, I strongly disagree with that.

Ms. MOONEY. And we continue to work with staff on the few remaining—the few documents under discussion, as well.

Mr. ROE. My time has expired. Maybe we can get a second round. Thank you, Mr. Chairman.

The CHAIRMAN. Ms. Brownley, recognized for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman.

And I appreciate all of you being here to answer the committee's questions this evening.

Mr. Chairman, I share your frustration. I'm very troubled by the slow pace of the VA's response to this crisis. What has happened in Phoenix and what is clearly happening at other facilities across this country, in my opinion, is unforgivable. We need decisive action now. Well-stated and good intentions just won't pass the muster. And as the Ranking Member Michaud stated in his opening remarks, we must have accountability, wherever it leads us.

And I sincerely believe that everyone in this room wants to ensure that our veterans receive the best possible care in a timely manner. But we will only achieve that goal when we have honest and open lines of communication from the VA. Our veterans deserve nothing less. And from the top down and the bottom up, the VA needs to level with this committee, it needs to level with our veterans across the country, it needs to level with the American people about what has happened and how we are going to fix it. And hiding the truth is absolutely unforgivable.

And the damages are compounded when we don't act quickly and decisively to learn all of the facts so that we can then act upon them. We need the truth, and we need the VA to be proactive, not reactive, and we need the truth now.

And I just wanted to make that statement. And I will ask my first question to Dr. Lynch.

Dr. Lynch, the chairman asked a question about the Greater West Los Angeles facility, and you answered some of his questions. I wanted to follow up on that. Given the fact that we are going to have a nationwide audit, I want to know the progress of those audits, and particularly as it relates to the West L.A. facility.

And I also want to know the steps that were taken in Phoenix with regards to destroying the work product, destroying the documents, after patients were inputted into the electronic system. Is that still occurring? Is that still a practice that's occurring in—I know not in Phoenix, but in other locations across the country?

And how are we actually handling, you know, patients right now who are waiting to be seen? You talked about the 1,700 veterans in Phoenix, but what about veterans across the country who are waiting for appointments, as well?

Dr. LYNCH. Congresswoman, let me try to take your questions in order.

The audit that has been going on by VHA across our system began a week ago. The first phase was focused on medical centers and community-based outpatient clinics serving greater than 10,000 patients. It is my understanding that the review at Greater Los Angeles has already occurred. I have not seen those results yet.

At the Secretary's insistence, that review has now been extended to all VA care facilities. I believe that second phase has been in process last week and this week.

Regarding other veterans across VHA, a process has been in place. Medical centers, all medical centers, have been asked to identify patients that have been placed on the wait list, patients who have been waiting for care. They are charged to submit that list to VA. And they are then going to be asked to review their resources. Can we provide care internally? If we can't, the plan is to contact those veterans, offer them care, if we can, in VA. If not, offer them care outside of VA.

Ms. BROWNLEY. And how long do you think that will take?

Dr. LYNCH. I don't have the time course. I know that the process has already been initiated, but I can't tell you exactly how long that's going to take.

Ms. BROWNLEY. But——

Dr. LYNCH. But I think the plan is that it should be done quickly. We appreciate your concern that we should not have veterans waiting.

Ms. BROWNLEY. And, I mean, how much time are you going to spend assessing the situation before we would actually contact veterans in other parts of the country?

Dr. LYNCH. I believe the plan was that the assessment should be completed within a week or less so that we can begin assessing our resources and contacting veterans.

Ms. BROWNLEY. Okay. Thank you.

So the other question that I had—and maybe this is for the Assistant Secretary Mooney. Oh, I apologize. I yield back. Hopefully I'll have another chance.

The CHAIRMAN. Thank you.

Mr. Flores, you're recognized for 5 minutes.

Mr. FLORES. Thank you, Chairman Miller.

I thank the panel for joining us today.

When the VA OIG went to Phoenix to look at what was actually happening there, they did what auditors typically do. They take a statistical sample of files, and they look to see what was reported and then what was actual.

And in the 226 that they—the sample set was 226 veterans, in this particular case. The original report from the Phoenix VA facility was that these 226 veterans waited an average of 24 days for their first primary care appointment and only 43 percent waited more than 14 days.

When the IG did their study of what actually happened on those same 226 cases, they determined that those same veterans actually waited an average of 115 days, with 84 percent waiting more than 14 days. And so, based on what they found in that sample, you have to extrapolate that and assume that all the appointment process is as broken as those 226 are.

So my question is this. Do we know who is responsible for reporting fraudulent numbers to the VA's central office? I mean, when you look at a VHA facility, who in that facility is responsible for reporting those numbers up the chain, so to speak?

Dr. LYNCH. Mr. Chairman, I think—I mean, Congressman, I'm sorry, I believe the responsibility for reports from the facility lie with the medical center director and with the network director.

Mr. FLORES. Okay.

I think you touched on this a minute ago. Now that we know who's doing it, what is the driver that causes them to engage in that activity?

One of the things that I've learned recently today based on another article that came out is that 50 percent of VHA executives' performance reviews are based upon wait times. Is that one of the primary drivers that's causing this misbehavior to occur?

Dr. LYNCH. Congressman, I don't know to what percent the wait-times measures contributed to the bonus of medical center directors and VISN directors. . I don't have that information.

I will reinforce what I said earlier. I think that, while well-intended, we had a performance measure that became a goal, and that created the potential that that information could be misused.

Mr. FLORES. I mean, the last time I saw an example of this, it was Enron, where the bonus system drove behavior. And we all know what happened at Enron. And I'm not suggesting that the VA is Enron, but it's something that I think that we need to look at, in terms of a flawed bonus system driving bad behavior.

That leads us to the next question. I mean, we've just said, or we've just heard testimony so far in this hearing that veterans really don't have to wait because there's a fee-for-service program where the VA will send them out to private-sector doctors. So if that's the case, so the VA can do this, why, then, do we still have the long waiting list? Is that because they're not really allowed to go out for fee-for-service?

Dr. LYNCH. I think that we had tried, prior to the information we had received. We had felt, however, that our core business was the delivery of primary care. We had tried to keep that within VA.

In retrospect, I think that was not a wise move. I think we did have the potential that patients were waiting. And we should have provided fee-basis services while we were trying to improve the processes so we could provide that care in-house.

Mr. FLORES. Okay.

There's a publication that I don't read very often, but it's called The Daily Beast. And their headline of a report they ran about 11 o'clock last night says, "Texas VA Run Like a 'Crime Syndicate,' Whistleblower Says."

It says, "Last week, President Obama pledged to address allegations of corruption and dangerous inefficiencies in the veterans' health care system. But before the President could deliver on his pledge, the scandal has spread even further. New whistleblower testimony and internal documents implicate an award-winning VA hospital in Texas in widespread wrongdoing—and what appears to be systemic fraud."

What they're—the facility they're talking about here is a facility in Temple, Texas. Are you aware of any similar issues that occurred in Phoenix as having occurred in Temple?

Dr. LYNCH. I'm not aware at this time.

Mr. FLORES. Okay. I would urge you to read this particular article, because they actually post pictures of the email chains that make it look like there is a coverup. In particular, there was one doctor who would just arbitrarily cancel appointments and then those appointments would have to be rescheduled.

So, thank you. I yield back.

The CHAIRMAN. Ms. Titus, you're recognized for 5 minutes.

Ms. TITUS. Thank you, Mr. Chairman. And thank you for holding this committee meeting late to accommodate those of us who had to fly back from the west coast. We appreciate that.

Like my colleagues, I, too, want to get to the bottom of this waiting-list problem in Phoenix and across the country. And many of my questions have been answered. The IG is not going to release,

as I understand it, the names of the other facilities that are being investigated, primarily to protect the whistleblowers. So I've asked that Nevada be added to that list, because I want to be sure that the veterans there are getting the kind of services that they deserve and there aren't any secret waiting lists.

I want to ask, kind of, a different line of questions because I think they go to the priorities. And I think priorities are, kind of, some of the problem that we're facing here as we look at the waiting-list issue.

Dr. Lynch, you mentioned that you went to Phoenix to check into the accusations that 40—and that was the number at the time—people had died as a result of this secret waiting list. You went on to note that you went on Thursday, April 17th. You spent the Easter weekend there with your wife. And then you were joined by two staffers on Monday, April 20th, to begin working on the issue and, in your words, understanding the climate.

I would just ask you, Doctor, to tell me how you could've possibly thought it was appropriate to turn such a critical, serious mission into a personal holiday. I mean, don't you just get that, that you were postponing looking into something that should've been looked into right away?

Dr. LYNCH. Congresswoman——

Ms. TITUS. And, also, tell me, then, how I can explain your actions to veterans who are worried about getting an appointment for possibly a lifesaving colonoscopy, not a tee time.

Dr. LYNCH. Congresswoman, I do not play golf, to begin with. And I take my job very seriously. It was the Easter weekend; I thought it was appropriate that my wife could join me. I spent Thursday and Friday working at the VA. I spent Monday and Tuesday working at the VA. There was nothing I could do over the weekend.

I subsequently went back to get more information, Congresswoman. I think I took the issues in Phoenix very carefully, very seriously. And I think what we found was shared with and confirmed by the inspector general. And I think, because of what I did in Phoenix, we were able to get people on the ground to begin the process of making recommendations for change.

So I'm sorry you misinterpreted my intentions. My intentions are to help veterans, to assure that they get good care, and to understand where our system is failing.

Mr. TITUS. That is our intention, too. And we feel like we need to work 24 hours a day, 7 days a week to make this happen, not taking holidays off. But I appreciate that.

And I yield back.

The CHAIRMAN. Thank you very much.

Mr. Denham, you're recognized for 5 minutes.

Mr. DENHAM. Thank you, Mr. Chairman.

Mr. Lynch, I just want to make sure that this is clear. You believe Phoenix is an isolated incident, or you believe this entire problem is a systemic issue?

Dr. LYNCH. I believe the inspector general has made it clear that this is a systemic issue, Congressman.

Mr. DENHAM. Okay. Because you originally started your testimony—this is something that goes back to 2005. We've had inves-

tigations over and over and asked for many different—there are 18 reports that have been identified coming back. You said in your testimony, October-November of 2012, there was a report that came back, and then we were working on this in 2013.

You talked about a glitch in the system. This does not seem to be a faulty computer system that we're dealing with here.

Dr. LYNCH. Congressman, I think I've made it clear that I think it's important that we need to keep our eye on what is the mission of VA.

And I think that we have elevated performance measures to goals. I don't think that's a glitch. I think that's a mistake, and I think that's something that needs to be corrected. I think we need to use performance measures for what they should be used for: management tools to identify where we have demand, where we don't have capacity, and how we're going to use our resources.

Mr. DENHAM. Sir, I don't think that anything is clear, at this point. And I think that's why you see so much frustration coming out of this committee. The only thing that's clear right now is that there are 40 brave soldiers that served that country proudly that died while waiting on a list. That's the only thing that's clear.

What's unclear is how much further this goes, how many other VA centers, how many other veterans are waiting. And we expect answers. That's all we're looking for here.

So you've started audits now beyond Phoenix.

Dr. LYNCH. Yes——

Mr. DENHAM. Forty-two audits have been started?

Dr. LYNCH. I'm sorry, sir?

Mr. DENHAM. Forty-two audits have been started now?

Dr. LYNCH. No, sir. We have reviewed, I believe, all of our 151 medical centers and, additionally, our major CBOCs. And we're now in the process of reviewing all of our health care-providing facilities.

Mr. DENHAM. So how many of them have been completed thus far?

Dr. LYNCH. I don't have that number, but certainly well over 200.

Mr. DENHAM. And your intent is not to share that with Congress?

Dr. LYNCH. I don't believe I said that.

Mr. DENHAM. Well, let me ask you, then. Is your intent to share that with Congress?

Dr. LYNCH. I—while I don't have responsibility for that particular report, I don't know why we would not share it with Congress.

Mr. DENHAM. It is my understanding that Palo Alto, in my area, has already conducted their audit. I had sent a letter on May 19th asking for not only an audit but a review. And now I'm told by the Palo Alto unit that it has been completed but we are unable to receive that information. So I'll make sure you get a copy of this letter, as well.

But I think every member of this committee, I think every Member of Congress is going to be looking at their local VA centers and wanting to know the truth on what's happening in their communities.

Dr. LYNCH. I'm sure they are. And that is proper and right.

Mr. DENHAM. Why is the VA returning money every year back to Congress?

Dr. LYNCH. Congressman, I can't comment on that. I don't manage the budget.

Mr. DENHAM. Why are we not using local doctors to come in and fill some of the voids that we're seeing in some of these different facilities?

Dr. LYNCH. We have been using local doctors. We do have a non-VA fee care program. We have implemented PC3, that is a program which uses community providers to provide care.

Mr. DENHAM. I will share this letter with you today, but I know of doctors in my area, in Stanislaus and San Joaquin Counties, that have asked to help out our veteran population. There's no reason, if there's money in the system and there's waiting lists, why we wouldn't be utilizing more doctors to fulfill those claims.

Dr. LYNCH. And we are going to be doing that.

Mr. DENHAM. Mr. Chairman, I'll present one of these letters for the record and provide Mr. Lynch the other one.

I yield back.

The CHAIRMAN. Without objection.

The CHAIRMAN. Ms. Kirkpatrick, you are now recognized for 5 minutes.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

Dr. Lynch, we all know there's a problem here, and I appreciate you're making it a priority to fix it and come up with solutions.

I'm the only Arizonan on this committee, and I'm also ranking member on the Oversight and Investigations committee, so I've been hearing from lots of veterans in Arizona. And that's my focus right now, even though I did call for a systemwide audit. But I want this fixed in Arizona so that we can get the veterans the care that they want and they need in a timely way, and that's what I'm hearing you say.

I really think listening to our veterans is key to resolving this issue. So my first question is, when you did your assessment at the Phoenix VA, did that include talking to the veterans who had experienced these delays?

Dr. LYNCH. I did not talk to any veterans during the course of that visit. I have subsequently received a phone call from one veteran who has had troubles with access, and I am working with him to assure that he gets the care he needs.

Ms. KIRKPATRICK. May I just suggest that we include our veterans maybe a little more in this process. I share somewhat the concern that Mr. Takano expressed, about how do we know we're getting accurate information. And I sometimes think getting it from a couple sources helps with that process. And I'm certainly hearing from a lot of——

Dr. LYNCH. I don't disagree with you. I think the veteran is our customer. I think we can learn a lot by talking to the veteran and the experience they have.

Mrs. KIRKPATRICK. And in verifying what the records show in terms of wait time, as well.

Dr. LYNCH. Yes.

Ms. KIRKPATRICK. You have identified the 1,700 patients who will be contacted by Friday. Can you tell us a little bit more of

what "contact" means? Does that mean an email or phone call? I mean, what does "contact" mean by Friday?

Dr. LYNCH. We are going to be using the central business office call center out of Topeka, Kansas. We will make an attempt to contact by telephone every veteran that is on that list.

If we cannot contact them, we will be sending them a registered or certified letter to assure that we have gotten in touch with them, that we have determined what their care needs are, and we have arranged for those care needs as necessary.

Ms. KIRKPATRICK. You know, I represent a large rural district. A lot of places don't have access to broadband, and a lot of places don't have mail delivery. I'm concerned that the rural veterans that I'm hearing from aren't going to be contacted in a timely way, and maybe I can work with you about some suggestions.

But I know that the VSOs would like to be very involved in this process. And sometimes they are the point of contact in these rural communities. So I'd just offer that as a suggestion.

Dr. LYNCH. Thank you. At this point, we are open to any suggestions that improve our process and help us contact the veterans.

Mrs. KIRKPATRICK. Now, my second question goes back to the original purpose of this hearing, which was responding to our subpoena. So, during your first visit to Phoenix, which was April 17th to 23rd——

Dr. LYNCH. Yes.

Mrs. KIRKPATRICK [continuing]. Did you receive or send any interim work product that in any way referenced the destruction or deletion of an alternative patient wait list?

Dr. LYNCH. To the best of my knowledge, Congresswoman, I don't believe I communicated any of that by email. I believed I communicated it to VHA central office when I came back, and I believe I communicated it to the committee staff the following day.

Mrs. KIRKPATRICK. Okay. Thank you.

And I yield back, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Mr. Runyan, you're recognized for 5 minutes.

Mr. RUNYAN. Thank you, Mr. Chairman.

Something I read in the OIG report today touches on this credibility issue, and I want to ask you a couple questions about it.

And, first, I'm going to paraphrase it. It's the last paragraph of page 4, where it says, "Certain audit controls within VistA were not enabled. This limited VHA and the OIG's ability to determine whether or not any malicious manipulation of the VistA data had occurred." To ensure proper oversight ability is not compromised—and the IG asked that it be turned back on.

Are they turned back on as of this day throughout the country?

Dr. LYNCH. I don't know, Congressman.

Mr. RUNYAN. Do you know what those switches——

Dr. LYNCH. I read the report——

Mr. RUNYAN.—were, or the audit controls would've been?

Dr. LYNCH. I read the report at 12:30. I'm not familiar with the audit controls. I can assure you I will find out, I will understand them, and they will be activated at the request of the IG.

Mr. RUNYAN. And, following up on those questions, as part of your proprietary software, do they have to be turned off, or do they

come out of the box in the "on" position? Was someone asked to do that?

Dr. LYNCH. I don't know.

Mr. RUNYAN. I would love to know that answer.

Dr. LYNCH. But those are good questions. Those are questions we need to ask. I will extend it. I will indicate that not only do we need to understand whether that was occurring in Phoenix and whether it's been corrected, we need to understand whether that was occurring elsewhere in our system, as well.

Mr. RUNYAN. Because it really not only compromises our ability to do our oversight job, it compromises your internal ability to do your own thing.

Dr. LYNCH. Congressman, we are attempting to put in place audit tools, and, clearly, if there's anything that makes those audit tools more effective, we are going to be assured—we are going to assure that they are functioning.

Mr. RUNYAN. I look forward to hearing that.

I have one question, going back to Mr. Huff.

Your notes were given to the general counsel, they were not destroyed, correct?

Mr. HUFF. Correct, Congressman.

Mr. RUNYAN. Thank you.

And, Chairman, I'll yield back.

The CHAIRMAN. Thank you very much.

Mr. Ruiz, you're recognized, 5 minutes.

Mr. RUIZ. Yes, sir. Thank you, Mr. Chairman, for holding this hearing.

I am deeply disturbed and furious about the recent reports of forged recordkeeping and veterans having the quality of their care negatively impacted due to long waiting times at VA facilities. The veterans in my district and across the Nation deserve better.

To begin the healing process of this broken trust, the VA must answer to this committee and, more importantly, to the veterans who served our country. Any VA leader or whoever knew about this breach of public trust and did nothing should be held accountable or resign.

I'm an emergency medicine doctor and know firsthand that delays for much-needed care can harm the patient. So let's take care of our patients. And this is the prescription to begin that process and what should be your priority right now:

First, do the right thing and immediately ensure that no other forged waiting list exists anywhere else.

Second, give our veterans the care they need as soon as possible and without delay. No more harm to our veterans.

Third, conduct this systemwide honest and transparent investigation and hold those found to be dishonest and negligent accountable. And help those who serve our veterans with excellence and distinction hire and train new employees who will show our veterans the respect and honor that they deserve.

As a physician, public servant, and, more importantly, as an American, I am committed to ensuring that all veterans receive the medical care they have earned and need when they need it and that those responsible are held responsible.

And as a public servant and advocate for veterans, I have written a letter to Director Stan Johnson, who oversees the Loma Linda VA health care System, to obtain additional information on how long veterans are waiting for care in my region.

Can you assure me that the Loma Linda VA health care System in my district is included in a systemwide honest and transparent investigation to ensure the veterans in my district are getting the care that they have earned and need?

Dr. LYNCH. To the best of my knowledge, Congressman, Loma Linda has been included in that process.

Mr. RUIZ. And from your expectations and performance metrics, can you comment on whether or not we have any forged waiting list there?

Dr. LYNCH. I cannot comment, Congressman, at this time. I have not looked specifically at the data from Loma Linda.

Mr. RUIZ. Okay.

Well, I look forward to working with you to ensure that the veterans in my district and everywhere else will get the care that they need when they need it and we can lower the waiting time so that this never happens again to any of our veterans.

Dr. LYNCH. I cannot disagree with you, Congressman.

Mr. RUIZ. Thank you very much.

Thank you, and I yield back my time.

The CHAIRMAN. Thank you, Doctor.

Dr. Benishek, you're recognized for 5 minutes.

Mr. BENISHEK. Thank you, Mr. Chairman.

Dr. Lynch, what's the name of the person who destroyed the waiting list?

Dr. LYNCH. I—first of all, I don't believe they were waiting lists. I think they were——

Mr. BENISHEK. Well, who destroyed the documents under question here, the name of the person?

Dr. LYNCH. They were schedulers who were working on the process of——

Mr. BENISHEK. Well, do you know their names?

Dr. LYNCH. No, I don't.

Mr. BENISHEK. Could we find out their names?

Dr. LYNCH. I don't know whether we can or not, Congressman. We can try.

Mr. BENISHEK. Well, you know, to me, you talk about the motive for this, and that the motive is that we're trying to do this right, you know, by complying with the rules and superfluous list, and there's danger of loss of getting their information. But that may not be the motive. The motive may be they're complying with, you know, somebody above who wants the waiting list to be shortened. So I think it's important that we identify the people that actually did the destruction of these things.

Ms. Mooney, who is the—what's the name of the general counsel that recommended that we don't have the items here we don't have?

Ms. MOONEY. Our general counsel, Will Gunn, is working with the committee on——

Mr. BENISHEK. Will Dunn is the name of the gentleman that says that this is a matter of privilege? His name is Will Dunn; is that what you're saying?

Ms. MOONEY. Our general counsel is Will Gunn.

Mr. BENISHEK. All right. Thank you.

Have any of you—Dr. Lynch, who is your immediate supervisor?

Dr. LYNCH. My immediate supervisor is, at the moment, Dr. Robert Jesse. We do not have a Deputy Under Secretary for Health for Operations and Management——

Mr. BENISHEK. Have you had any conversation with—or any communication at all with Dr. Jesse about your testimony here today prior to——

Dr. LYNCH. I met with him briefly this afternoon so that I understood exactly what our way forward was following the release of the IG report.

Mr. BENISHEK. Did he have any recommendation for your testimony?

Dr. LYNCH. Only to explain where we were going and how we were going to address——

Mr. BENISHEK. Do you have any documentation of your conversation?

Dr. LYNCH. No, I don't.

Mr. BENISHEK. Ms. Mooney, who is your immediate supervisor?

Ms. MOONEY. Sloan Gibson, our Deputy Secretary.

Mr. BENISHEK. Have you had any conversation with Sloan Gibson about your testimony here today?

Ms. MOONEY. Brief, in passing, in the morning.

Mr. BENISHEK. But no documentation of any of that communication?

Ms. MOONEY. No, sir.

Mr. BENISHEK. Mr. Huff, who's your immediate supervisor?

Mr. HUFF. Mr. Mark Hone.

Mr. BENISHEK. Mark—what's his last—Mark who?

Mr. HUFF. Hone.

Mr. BENISHEK. Okay. Have you had any conversation with Mr. Hone about your testimony here today?

Mr. HUFF. Yes, sir.

Mr. BENISHEK. And what was the nature of that conversation or communication?

Mr. HUFF. To provide clear, accurate, and honest responses to your questions.

Mr. BENISHEK. You know, it is very troubling to me that we talk about accountability and making sure we know the facts here, but when you don't know the name of the people that actually did the destruction, it seems like that would be the first thing, when you went to Phoenix, you'd find out who did it.

Dr. LYNCH. So, Congressman, my goal in going to Phoenix was to understand the process. I knew that the inspector general was there. They were there to assess intent and to identify if there was responsibility or accountability for——

Mr. BENISHEK. But without names of people, how does that occur? I mean, how does—don't you ask the person, why did you destroy this evidence, these lists, why did you do it?

Dr. LYNCH. These—I did not speak to any of the schedulers——

Mr. BENISHEK. Did anyone on your staff do that?

Dr. LYNCH. Pardon?

Mr. BENISHEK. Did anyone on your staff—I mean, you mentioned that you found about it through a member of your staff.

Dr. LYNCH. I don't know whether the staff had spoken directly with the schedulers who may have been involved inthe——

Mr. BENISHEK. What was the name of that staff member again?

Dr. LYNCH. Pardon?

Mr. BENISHEK. The name of the staff member?

Dr. LYNCH. I was there with Dr. Mike Davies.

Mr. BENISHEK. So did Mr. Davies talk to anybody at the Phoenix staff that may have actually done the destruction?

Dr. LYNCH. I don't know, Congressman.

Mr. BENISHEK. I just don't understand how you can conduct an investigation about the alleged destruction of documents and not actually talk to anybody or know the name of anybody who actually did the destruction or their motive.

Dr. LYNCH. I felt that was the IG's function. They were there to identify——

Mr. BENISHEK. Well, no, I thought you went there to figure out what was going on.

Dr. LYNCH. I was there to understand the process. And I think I accomplished——

Mr. BENISHEK. But wouldn't the process be identifying the person who actually did the destruction of the documents?

Dr. LYNCH. I did not——

Mr. BENISHEK. Don't you have any interest in who did it?

Dr. LYNCH. I did not think that was necessary at the time, Congressman——

Mr. BENISHEK. It would seem to me that'd be the first thing you'd ask. I mean, maybe I'm just simpleminded, but there's a question about destruction of documents, and you don't even know who did it or their motive.

Dr. LYNCH. I believe I understood the motive at the time.

Mr. BENISHEK. Well, but your contention to me is that the motive was just and within the realm of the VA and protecting the patients' records, where I'm suggesting to you that there's a possibility that there's motivation within the VA that encourages people to shorten waiting lists so that they get bonuses. Do you understand my concern about that?

Dr. LYNCH. I understand your concern.

Mr. BENISHEK. Wouldn't that be something that you might be concerned about, that you might question the people that were doing the destruction if they had any communication with their supervisors, that they might be pressured to do things that would allow their supervisors to get bonuses?

Dr. LYNCH. That is a discussion the IG is having.

Mr. BENISHEK. Well, why wouldn't you have that discussion?

Dr. LYNCH. Because my goal, Congressman, was to understand the process so that we could——

Mr. BENISHEK. But you can't understand the process if you don't understand who did it and their motivation.

I yield back my time.

The CHAIRMAN. Thank you.

Ms. Kuster, you're recognized for 5 minutes.

Ms. KUSTER. Thank you very much, Mr. Chairman.

And thank you to our witnesses for appearing hearing today this late in the evening.

I share the horror, frankly, of the allegations coming from the VA facilities around the country, including the VA Phoenix facility, on the long patient wait times and, more importantly, the alleged misreporting of those patient wait times and what's been referred to in the report as gaming of scheduling.

Needless to say, I think this is not a partisan issue, but we find this completely unacceptable. And I appreciate your attempt to determine what was wrong and who's responsible and how to move forward.

The question that I have is, as you've raised a number of times in your testimony, Dr. Lynch, a question of integrity and a question of accountability. Because, obviously, the interim IG report indicates mass systemic problems with long patient wait times and inaccurate reporting and this gaming that's been going on.

My question is, this has been going on, apparently, since 2005, I assume well before you were in your current positions, well before Secretary Shinseki was in his current position. But in recent months has Secretary Shinseki, in his role as leader of the VA, been aware of these systemic problems? And why were these issues not immediately addressed, given this long line of IG reports over the past 10 years?

Dr. LYNCH. Congresswoman, I think that, to a certain extent, we failed to challenge our assumptions. We believed our numbers. We felt that the IG reports and patient complaints were exceptions and not rules. I acknowledge that, in retrospect, that should not have happened.

I would also indicate that, during this time, there were people who were trying very hard, with the best of intentions, to identify methods by which we could monitor veteran access to VA care. It has been a challenge. We have tried multiple different models. It has been a challenge for the private sector. There isn't a right answer here.

We were trying to find a solution. I believe we probably incorrectly assumed we had a solution. It has become painfully obvious that we had set our system up to give us incorrect information, and we need to assure that doesn't happen again.

Ms. KUSTER. And in terms of my question about Secretary Shinseki's role, was he involved in this?

Dr. LYNCH. The Secretary has been aware and, I can assure you, has been asking questions and directing activities to assure that we move to a quick resolution of this problem.

Ms. KUSTER. And with regard—I want to go back to one of the documents in the report that's a Department of Veterans Affairs memorandum, April 26th, 2010. It's one of the attachments, Appendix E.

And there was a gaming strategy that concerns me. As a way to combat missed opportunity rates, some medical centers cancel appointments for patients not checked in 10 to 15 minutes prior to their scheduled appointment time.

Some of the stories that we've heard about are veterans who think they have an appointment; they go to the appointment, and they're told they don't have an appointment, even if they have a card with an appointment. It seems to me that this has become an issue that gets exacerbated. Then these people are not being seen in a timely way, in terms of the continuity of care.

Have you had reports from physicians of their frustration trying to treat our veterans in a timely, compassionate, and high-quality way?

Dr. LYNCH. I have not had individual complaints from physicians. I was a VA physician before I took this position. I valued my encounters with veterans. I hope that I have provided good care.

I share your concerns about any mechanism that games our system, not only because it hurts a veteran but because it doesn't give us the information we need to make our system better.

Ms. KUSTER. Thank you very much.

I yield back my 2 seconds.

The CHAIRMAN. Mr. Huelskamp, you're recognized for 5 minutes.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

The first question I have would be for Ms. Mooney.

I believe you've articulated the assertion of attorney-client privilege and have referenced that numerous times. Would you identify for the committee who is the client that you're asking for that privilege?

Ms. MOONEY. I would just defer that to the Office of General Counsel.

Mr. HUELSKAMP. Has that been identified for the committee exactly, the client that the attorney-client privilege is being asserted by the Office of General Counsel?

Ms. MOONEY. Attorney-client privilege——

Mr. HUELSKAMP. Well, there has to be a client, clearly. Who is the client? Who is refusing to provide information to this committee and to the American public about this issue?

Ms. MOONEY. Mr. Huelskamp, I know that the Office of General Counsel is working with the committee staff on that.

Mr. HUELSKAMP. Okay. So you do not know, or refuse to reveal. Do you know——

The CHAIRMAN. Mr. Huelskamp——

Mr. HUELSKAMP [continuing]. Who the client is?

Ms. MOONEY. Mr. Huelskamp, I'm not with the Office of General Counsel.

The CHAIRMAN. If the gentlemen will yield?

Mr. HUELSKAMP. Yes, sir.

The CHAIRMAN. All we know is that it is one of the eight people who has, in fact, been subpoenaed. That is—we haven't been given a name yet. But to answer your question, it is one of the eight people.

Mr. HUELSKAMP. Thank you, Mr. Chairman. In my understanding of that privilege, we get the privilege of knowing who the client is. And that should've been noted in the original refusal to provide the information.

I'd like to return to Dr. Lynch, as well, and returning to your trip to Phoenix. And you're apparently not surprised by the OIG report?

Dr. LYNCH. No, Congressman, I'm not.

Mr. HUELSKAMP. And what actions have you taken in the 5 weeks since that report? If you could describe those—or since your visit?

Dr. LYNCH. I'm not sure it's—well, maybe it is 5 weeks.

We have had two teams in Phoenix since my visit, one working with the scheduling team, the other working with the clinics to improve their care-delivery process.

Mr. HUELSKAMP. Have they identified the 1,700 individuals that were revealed in the OIG report?

Dr. LYNCH. We did not identify the 1,700, Congressman.

Mr. HUELSKAMP. You've described the, obviously, electronic waiting list, which is not secret. You've referenced numerous times about the interim, or intermediate list. How many names were on that interim, intermediate list?

Dr. LYNCH. I don't know, Congressman, because I suspect there were multiple lists as patients were cancelled. The list of the patients that were cancelled were printed out and the patients were rescheduled.

Mr. HUELSKAMP. And these were all destroyed?

Dr. LYNCH. To my knowledge, they were destroyed, Congressman.

Mr. HUELSKAMP. So no idea how many names were on the destroyed interim waiting list?

Dr. LYNCH. They were not available for me to——

Mr. HUELSKAMP. Did you observe that?

Dr. LYNCH. Pardon?

Mr. HUELSKAMP. Did you see the list?

Dr. LYNCH. I did not. I have——

Mr. HUELSKAMP. How did you know it existed?

Dr. LYNCH. I have seen an example of what the list looks like.

Mr. HUELSKAMP. How did you know it existed?

Dr. LYNCH. Because the people we talked to told us that——

Mr. HUELSKAMP. Did you visit with the director of the Phoenix clinic about the list?

Dr. LYNCH. I did not. We visited with folks in their scheduling office——

Mr. HUELSKAMP. Who made the decision to take away her bonus?

Dr. LYNCH. I'm sorry?

Mr. HUELSKAMP. Wasn't her bonus removed after your visit, or rescinded?

Dr. LYNCH. That was, I believe, within the last week. That was not my decision. That was the Secretary's decision.

Mr. HUELSKAMP. It was rescinded?

Dr. LYNCH. Yes.

Mr. HUELSKAMP. But you did not visit at all with the director of the clinic when you went to do your investigation?

Dr. LYNCH. There are multiple clinics——

Mr. HUELSKAMP. Yes or no, did you visit with the director of the clinic?

Dr. LYNCH. Actually, I did.

Mr. HUELSKAMP. Tell us the conversation.

Dr. LYNCH. We talked to him about his process of trying to improve the availability——

Mr. HUELSKAMP. Did you discuss the destruction of the interim waiting list?

Dr. LYNCH. No, I did not.

Mr. HUELSKAMP. Did you know about it when you visited with the director?

Dr. LYNCH. I did.

Mr. HUELSKAMP. And you chose not to bring it up why?

Dr. LYNCH. Because it did not appear to be in his area of responsibility. His area of responsibility was the clinic. Scheduling——

Mr. HUELSKAMP. Which just happens to be the waiting list.

Dr. LYNCH. Pardon?

Mr. HUELSKAMP. Two other items I'd like to address. In addition to the interim list that's been destroyed, there's also three other lists. Thank goodness, we have those. OIG found those. That's the NEAR tracking report, the screenshot paper printouts, the schedule-an-appointment consult. That's how we identified 1,700 veterans who were denied care.

I would say this was a secret. We were lucky, I guess, that we found those. Do those types of lists exist throughout the entire VA system?

Dr. LYNCH. I don't know.

Mr. HUELSKAMP. You're the expert in the process. You don't know if there's a NEAR tracking system in other clinics?

Dr. LYNCH. The NEAR list is available to every medical center.

Mr. HUELSKAMP. So every medical center could have a NEAR list with, potentially, another secret waiting list?

Dr. LYNCH. The NEAR list is not secret, but they could have——

Mr. HUELSKAMP. How did you not know about the list if it's not secret?

Dr. LYNCH. I'm sorry?

Mr. HUELSKAMP. They identified 1,100 veterans sitting on this list who were denied care. Some of them might not be alive today because you waited 35 days and did nothing as far as changing that.

I yield back, Mr. Chairman.

The CHAIRMAN. Mr. O'Rourke, you're recognized for 5 minutes.

Mr. O'ROURKE. Thank you, Mr. Chair.

And, Mr. Chairman, I'd like to begin my remarks by sharing the frustration expressed so far by the committee members and also members of the panel, but also making clear that my frustration, at least, does not extend to the providers.

I think about the providers at the El Paso VHA, many of whom—doctors, nurse practitioners, nurses, psychologists, therapists, counselors—could be working in the private sector for more money, could be working with the Department of Defense for more money, could within the VA system be working at other VHA facilities other than El Paso for more money. And they're working to serve the veterans in our community that I have the honor of representing because they want to help them and, in many cases, they themselves are veterans.

So I think that message is too often lost in our justified criticism of the management of VA leadership here in Washington, DC. at VA leadership within the VISNs, and at some of the local VHAs.

When I hold town hall meetings in El Paso—and I hold one every single month, and I hold a veterans-specific town hall every quarter—most of the concerns raised at those town halls are about wait times. And it flew in the face of the information and the data that I was receiving from the El Paso VHA, which showed that our wait times were on par with national levels and were very close to the targets set by the VA.

And so what we decided to do was actually hire somebody to go and do what many people here suggested, which is to actually talk to the veterans and not just listen to them at these town hall meetings but actually conduct a scientific survey in El Paso. And we surveyed 692 veterans, with an error margin of plus or minus 3.8 percent, and found that the variance from what the El Paso VHA was reporting for primary and mental health care times was wildly different from what our veterans were reporting.

For example, in December 2013, VA reported that 70 percent of new El Paso VA patients saw a mental health provider in 14 days. Our survey showed that 36.5 percent of our respondents could not even get an appointment at all and just completely dropped out of the system. On average, a veteran's mental health care appointment, when it was set, was cancelled once. Forty-two percent of our respondents completely put off getting mental health care because of the difficulty in obtaining an appointment.

I don't need to draw the connection, but I will, that when we delay care, we're often denying care. And this is at a time when we're seeing, on average, 22 veterans taking their own lives every single day. So this is a life-and-death issue in Phoenix, but it's a life-and-death issue in El Paso, and it's a life-and-death issue, I'd argue, across the country.

So as much as I would also like to get to the bottom of what happened in Phoenix and know who destroyed which records and who made what decisions, I think this is a problem that is much larger than just Phoenix, much larger than just El Paso, though we see similar problems there, as well.

So, as the chairman has asked and others have asked, I'm asking you to look into the specific issues in El Paso. We'll provide you all the data that we collected.

I'd also like you to look into allegations that we've heard in El Paso, confirmed by the OIG's report, that appointments are set for veterans who request an appointment, but the veteran is never informed that that appointment has been set. And so when the veteran does not show up for that appointment that he did not know about because no one informed him, it shows up on the veteran's record that he declined to come in or failed to show up and does not harm the VA's record in terms of performance on wait times.

We have heard that anecdotally oftentimes in El Paso. We're seeing it in the OIG report. I hope that you will look into that as part of your systemwide audit.

Lastly——

Dr. LYNCH. Congressman, we are. And I would be happy to meet with you personally to get the information that you have, that you've obtained from the veterans.

Mr. O'ROURKE. Thank you.

Dr. LYNCH. I would value looking at that.

Mr. O'ROURKE. And I think that's why Phoenix resonates throughout this country. Beyond the tragedy of apparently 40 veterans losing their lives because of gross negligence within that facility, it seems to confirm what so many of us are hearing every single day in our districts. So I appreciate your tenacity in pursuing the facts and reporting those back to this committee.

And, lastly, for Ms. Mooney, on the 29th of April, Congressman Pete Gallego and myself sent a letter to the Secretary asking specifically about the El Paso VA and whether similar practices were conducted there and a very simple question about whether a secret wait list was maintained there.

We have still not received a response to our letter. When can we expect a response?

Ms. MOONEY. I know the results of the nationwide audit will be forthcoming, and those results will be shared with the Congress. And we look forward to answering your response and all the Members' responses about individual facilities at that time in the very near future.

Mr. O'ROURKE. Mr. Chair, I yield back.

The CHAIRMAN. Thank you.

Mr. Coffman, you're recognized for 5 minutes.

Mr. COFFMAN. Thank you, Mr. Chairman.

Dr. Lynch, the Office of Inspector General indicated that it had received allegations of retaliation against whistleblowers in Phoenix. What is VA doing to make sure it does not engage in such prohibited personnel practices?

Dr. LYNCH. I'm sorry, I'm not quite sure I understand the question. I have—I did not see the allegations regarding retaliation. I believe the IG will probably give us a complete report about any of those concerns. And it would be my expectation that if there was inappropriate retaliation it will be addressed.

Mr. COFFMAN. What was the name of the doctor, the retired doctor, from the Phoenix hospital that was a whistleblower? What was his name?

Dr. LYNCH. Dr. Foote?

Mr. COFFMAN. Oh, Dr. Foote. How was your meeting with Dr. Foote? How did it go?

Dr. LYNCH. I did not meet with Dr. Foote.

Mr. COFFMAN. Oh, you didn't meet with Dr. Foote. Did you ask for a meeting with Dr. Foote?

Dr. LYNCH. I did not.

Mr. COFFMAN. Oh. And why didn't you ask for a meeting? I mean, here is somebody that clearly was at the center of the storm. You're there to understand what the process was, and yet you didn't request a meeting with Dr. Foote.

Dr. LYNCH. I, at the time, was concerned that it might interfere with the IG's investigation.

Mr. COFFMAN. You know, I think that your concern was it might interfere with the truth. And I've got to tell you, how far this problem goes. Because the fingerprints of you all that are at this panel today are all over this problem. Because I can tell you, you are not being forthright in your testimony.

And I think the model for the Veterans Administration—and let me tell you, there are a lot of good young men and women—or, I

mean, of all ages, that work for the Veterans Administration, the rank and file. And some of them are the whistleblowers. Because without them we would have no idea what's going on, because the leadership of the VA simply is not there.

And the tragedy here is that the impression that you give, all three of you today, is that you are here to serve yourselves and not the men and women that have made extraordinary sacrifices defending this country.

And I've got to tell you, nothing will change in the Veterans Administration until we have new leadership, and not just from the very top, General Shinseki, but all of you, I think, got to find something else to do. Because you're not here to do your job.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Walz, you're recognized for 5 minutes.

Mr. WALZ. Thank you, Mr. Chairman.

Well, as so many of my colleagues have alluded to during their testimony, this issue of trust is fundamental in any relationship. It's especially true in the trust of our Nation to their veterans, the veterans to the VA, the VA and Congress working in concert together. And I think that, being on this committee over the years and watching this, there has been a cautiousness that maybe, as some have alluded to, is the nature of any bureaucracy. Over the years, it appears that cautiousness has moved more towards a paranoia or, as Mr. Takano said, a bunker mentality.

And the interchange with Mr. Denham and Dr. Lynch was very interesting. Mr. Denham was talking about the audit that was being done, and he asked the Assistant Deputy Under Secretary for Health and Clinical Operations if we were going to get that list, and there was a pause and a cautiousness.

I don't understand—I know your hearts are in the right place, but the bureaucracy or whatever is holding you back. I can't imagine a scenario or a world, Dr. Lynch, where you would let someone in a bureaucracy not get Mr. Denham or myself that information, why you wouldn't have just gone out on a limb right at that table and said, "I'll get it, and if they don't like it, too bad."

And that mentality gets us to where we're at today, because what we're all trying to do is solve this problem to provide timely, quality care for our veterans they've earned and deserve. And everyone gets that—the folks sitting behind you repping the VSOs, you, us here. But the problem is no competent leader is going to formulate a course of action with all pertinent data.

And I was under the naive impression, apparently, that our constitutionally mandated oversight responsibility is, when we ask for a very narrow subpoena—I would hope it wouldn't have had to have been a subpoena. But I was under the impression this is what this would look like: You would go back and say, from this date to this date, which I can do on my computer, print out—and I thought there might be a whole bunch of interns taking stacks of emails, some of which might say, "Happy birthday, Mary; today we're having pie," or other things that were pertinent, and those would be here, and this committee would decide what was important.

Mr. WALZ. But I was mistaken because now I already know the answer. So you don't have to—I will give you the opportunity to do

so out of courtesy, but the answer is going to be you should ask the general counsel, Mr. Walz.

Is there a team of lawyers over there putting things in stack and saying, "This is going to go. This is attorney-client privilege"? And is there somebody over there putting something in executive privilege stacks? Do any of you know that? Is there an executive privilege stack over there of these? Anybody know the answer?

Dr. LYNCH. Congressman, I don't know the answer. I can let you know that I have met with this committee, with this committee's staff, with this chairman on a number of occasions to share what I know about VA and VHA health care. I, for one, value the relationship with Congress. I, for one, am looking for a collaborative relationship.

Mr. WALZ. Am I wrong to believe it is strained?

Ms. Mooney, I am going to ask you that. We have known each other for quite some time and worked together.

Are you under the impression that this relationship has been strained for a while between Congress and the VA with your congressional liaison?

Ms. MOONEY. Congressman, that is not our intent, that it be strained. Our intent is to be open, transparent, collaborative and work closely with you.

Mr. WALZ. Have you ever heard from anyone on this panel that they felt it might have been strained?

Ms. MOONEY. Yes, sir. I have heard that. Yes. And many of you talk to us about issues that you face, and we work to get you information as quickly as we can.

On the subpoena we worked—and we understand the constraints—we worked for 2½ weeks, the Office of General Counsel, to provide the committee with a response——

Mr. WALZ. Was that an unrealistic scenario of me to—I truly did expect that you were just going to send a pile of stuff over here and these staffers, with the direction of Congress, were going to sort through and decide what needed to be done.

Was that a naive assumption? And I say that not leading and not passively aggressively. Is that naive in terms of subpoenas?

Ms. MOONEY. Congressman, I know that this was run out of the Office of General Counsel; so, I would defer to them. I was not part of that process. And I don't think anyone on the panel can speak to that.

Mr. WALZ. And I think many of us on this committee have proven ourselves of what we want to do and the trust witnessed, whatever.

But I am with Dr. Roe. I can't help but feel something has not been given to me. And that may be totally false, but the impression was there.

I would have just loved to see you, Dr. Lynch, jump up and say, "Over my dead body will you not get that report." Can you say——

Dr. LYNCH. Congressman, I have no doubt that this committee will get that report. I just do not have responsibility for it. But I have no doubt that the people——

Mr. WALZ. So now the person who is responsible is not here; so, we may have to bring them in and ask them to give us.

Ms. MOONEY. On the audit——

Mr. WALZ. What is the job of the congressional liaison? What is the job of—who do we talk to? Are you there for us to talk to to ask these questions or should we just skip over you and go directly to general counsel?

Ms. MOONEY. Yes, Congressman. In a subpoena, that is a legal matter. We work with members of this committee and their staff pretty much——

Mr. WALZ. We tried to do it without a subpoena.

Ms. MOONEY [continuing]. Every day

Mr. WALZ. We tried to do it without a subpoena.

I yield back.

Ms. MOONEY [continuing]. Every day.

The CHAIRMAN. Thank you very much, Mr. Walz.

Dr. Wenstrup, you are recognized for 5 minutes.

Mr. WENSTRUP. I thank you very much, Mr. Chairman.

You know, as a veteran and as a physician, I have serious concerns, obviously, like the rest of this committee. But let me ask a few questions.

Why were so many patients canceled?

Dr. LYNCH. They were canceled in an effort to reschedule them more timely, first of all.

Mr. WENSTRUP. To have them seen sooner?

Dr. LYNCH. To have them seen sooner.

Mr. WENSTRUP. So they were canceled and to be seen sooner.

Dr. LYNCH. And rescheduled sooner.

Mr. WENSTRUP. Were they all new patients or were some of them follow-up visits?

Dr. LYNCH. Historically in Phoenix, as I understand it, the administration prior—the management prior to Ms. Helman had used a model where they had not employed the wait list. They had simply scheduled patients whenever there was an appointment. It could be 6 months out. It could be 7 months out.

With the new team, there was a desire to identify additional appointment slots, which they did. They then went out, identified those patients who had been scheduled 3, 4, 5 months in advance, canceled those appointments and brought them into a new appointment slot.

Mr. WENSTRUP. Do doctors weigh in on the immediacy of some rescheduling? So if someone is being rescheduled, do they actually say, "No. That patient is very sick. I need to see them tomorrow. They need to get in here right away"?

Because I know, in my private practice, if for any reason we are rescheduling someone, I will tell you it was very rare that we were moving them up. Okay? But if we needed to because they called, we would do that.

But, also, we would discuss on a patient-by-patient basis, "This patient needs to be seen right away. They can't wait."

Does that ever happen or are the doctors out of this situation altogether?

Dr. LYNCH. I cannot tell you whether the doctors were involved in the rescheduling process that occurred in Phoenix.

Mr. WENSTRUP. So we don't know if doctors, in general, in the VA are able to weigh in on the risk associated with a patient waiting longer for a procedure?

Because certainly we are talking about people waiting for colonoscopies. They weren't canceled to be moved up. They were delayed. They were delayed.

So do doctors get to weigh in and say, "This patient needs to be in here right now it is important." Does that happen? Because it happens in private practice.

Dr. LYNCH. I believe it does happen. I believe that physicians can review consults and identify, based on the——

Mr. WENSTRUP. Can or do they? I mean, can—I imagine they can. I would hope that they have access to their patients' records. But does this take place?

Dr. LYNCH. I believe they do.

Mr. WENSTRUP. Because, you know, in private practice, a hospital or clinic is not going to let a lot of patients sit on a waiting list.

They are going to get them in to be seen because their very existence depends on that. And that's a different model than exists at the VA currently.

So the other is what Dr. Roe alluded to before. Does the drive to get patients to fee-based care come from the problems that have arisen recently or is that something that's really been embraced with energy?

And the other question I have is: Are those that are receiving bonuses penalized if they send more patients to fee-basis care? Do you know that?

Dr. LYNCH. Congressman, I do not believe they are penalized if they send more patients to fee-basis care. I believe that we have been putting in place the tools that have allowed greater use of fee-basis care when we can't provide the service.

Mr. WENSTRUP. Because, you know, part of performance is really access and productivity as well as results of taking care of patients.

So I just have one other thing to say. When it comes to the Office of General Counsel, if you are turning everything over and you have nothing you are concerned about that we should find out about, you should be very upset that they have not turned this information over to us.

You should be screaming and yelling that they have not turned that over to us instead of reciting time and time again, "I defer to them." You should fire them. You should stand up for yourself and say, "I have turned everything over and here it is so that you can evaluate it."

Do you have any comments on that on a personal note? Don't you feel that you are being let down? Because people are asking you here tonight, "Where is this information?" You say you have turned it over, and they are saying, "Hold it." Doesn't that bother you? Because they are not helping your name tonight.

Ms. MOONEY. I have turned over the information—I haven't turned over the information. They have gone and pulled my email files.

Mr. WENSTRUP. Doesn't that bother you, that they haven't submitted it to us?

Ms. MOONEY. Sir, I haven't reviewed the email files. I——

Mr. WENSTRUP. So it doesn't bother you, apparently.

Ms. MOONEY. We are committed at VA to being collaborative and responsive.

Mr. WENSTRUP. Our veterans in a time in their life responded to the Nation's needs immediately. They dropped everything and did it immediately. I would hope you would do the same.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you very much, Doctor.

Per committee rules, we will continue with membership and then we'll go to Ms. Jackson Lee.

So, Mr. Cook, Colonel, United States Marine Corps retired, you are recognized for 5 minutes.

Mr. COOK. Thank you, Mr. Chairman.

You know, this whole issue is very, very disturbing. You know, it is ironic. This was Memorial Day. I think we all gave a lot of speeches. It kind of turned into Memorial Day/Veterans Day because this was the number one issue when you would talk to the military and the veterans. They want to know what's going on, what's happening.

And somebody mentioned earlier Omar Bradley. I was a young second lieutenant in Vietnam that met Omar Bradley because we got shot up pretty bad and my unit—they wanted it. And I came back and I talked to him.

And he said he wanted to talk about the M-16. And I told him—I said, "It is a piece of crap," you know, "It doesn't fire right," you know, all the things at that time. And that was 1967. You know, most of you people weren't even born then.

But, you know, he was 80-something years old. He was taking notes. And then suddenly after that there were all kinds of investigations, changes to the system to change it so that no one else would die because of a weapons failure. And that weapon is still being used today in the U.S. military, the longest weapon we ever had.

And I think, "What if General Bradley were here now, the last five-star general we had?" It is kind of ironic. Next week, Normandy Invasion, 6th of June. I just don't feel that there's a chain of command or a sense of urgency.

You know, I am not going to go over all the things that have been covered and everything like that, but my feeling is, "Who is going to go down there and correct these things?"

And, you know, I know you had a busy weekend. But if people are dying there, you have got to work through the weekend. It is a 24-hour day. It is a 7-day work—you know, there's got to be a sense of urgency.

And I am coming away from this hearing that the lawyers run everything. There has to be certain decisions made right away to change some of these policies, whether certain people have to be fired, whether they don't get bonuses.

There is a lot of great people out there, I am sure, that work for the VA, but most of them are military. And they are probably frustrated.

And what I am getting up to is I think right now—you know, we are going to talk about this and this committee will make a report and everything like that.

But I was going to ask you, you know, the chain of command, who is going to do this, this and this. I just come away from this hearing tonight and I get the feeling that no one in the VA right now is in a position to do anything.

There is no trust and confidence to the people that I talked about. They want action and they want it now. And if certain people—like if I did something wrong and people died, I would be fired and probably court-martialed.

And that is the nature of the business. We owe that to the veterans, to the military, and we owe that to all the people that are working so hard in the VA Administration.

We have to straighten out this problem right now. We can have subpoenas and everything else, and I haven't heard that. I'd like to see the President go down to the VA hospitals and meet with the veterans. I'd like to meet—you know, if it were possible, to go down there right now and talk to them, you know, investigate and take statements of everybody. We have all done it before.

And so I am just very, very frustrated that—you know, that I am in a position to make a difference and I can't do anything. You know, I can't get across to you or the whole—and it is a feeling of frustration. If I was smarter than most people here, I'd say, "Okay. You have got to do this, this, this and this."

But right now I think you need the discipline to go down there. Certain people have got to be relieved. They have got to be fired. These policies have got to be changed almost overnight. And we can't accept excuses or the fact that the lawyers are handling it anymore.

Sorry. I should have asked questions, but that has been something that has been bugging me. And I apologize. Thank you.

I yield back my 1 second.

The CHAIRMAN. Colonel, thank you for your service to this country. We are honored to have you as part of our committee.

For the record, there are close to 700 attorneys at the Department of Veterans Affairs.

Ms. Walorski, you are recognized for 5 minutes.

Ms. WALORSKI. Thank you, Mr. Chairman.

Mr. Lynch, I sit here and the—I don't think there is a word in the English language that can describe how frustrated I am, and I even think frustrated is an understatement.

I have sat here for 18 months and listened to the same kind of answers we have heard tonight. And we have sat here for 2 hours and 15 minutes. We have had 20-some people question the three of you. And I know now, 2 1/2 hours later, what you don't know.

You actually traveled to Arizona and you didn't meet with anybody that had anything to do with this directly. You took your wife. It was Easter weekend. We understand that plan. You didn't meet with anybody that was directly involved, from all the testimony of these 20 people right here.

If I was in your shoes, I would describe this as a five-alarm fire and you are rushing to the scene and you are bringing mutual aide because the house is on fire and nobody's going to survive.

And I sit here and listen to the three of you and I am thinking to myself the question I leave here tonight with and probably my colleagues: What do you know? What we know is that people died.

So I guess the question I want to ask would be on behalf of the families that probably aren't in this room tonight, but we have heard from some of them. I heard from Barry Coates here 3 weeks ago that has a death sentence and a death warrant for something that was no fault of his own because he couldn't get a simple colonoscopy.

People died. We sit here and we are going to—we are asking all the same questions. But if you have an opportunity, I am going to give you an opportunity because you are all three sitting here. This is carried live.

What do you want to say, Mr. Lynch, to the families of these people that lost veterans? What do you want to say on behalf of the VA? Here is your opportunity.

Dr. LYNCH. Congresswoman, on behalf of myself, first of all, I take personally any time that a veteran has been harmed because of something the VA has done wrong.

Ms. WALORSKI. Dr. Lynch, does the buck stop with you on these deaths? Do you accept the bulk of the responsibility for what's happened? Are you responsible?

Dr. LYNCH. Congresswoman——

Ms. WALORSKI. Yes or no. Are you responsible? Does the buck stop with you, Dr. Lynch?

Dr. LYNCH. I don't know whether it does, but I consider myself responsible, Congresswoman.

Ms. WALORSKI. Ms. Mooney, does the buck stop with you? Do you feel responsible? Can you look in the eyes of these families and say, "I accept this responsibility?"

Ms. MOONEY. Congresswoman, I am the daughter of an atomic veteran.

Ms. WALORSKI. Yes or no. Are you responsible?

Ms. MOONEY. Yes. I am responsible for ensuring that our focus at this point—and I am sorry, Mr. Cook, that we didn't make this perfectly clear to you—our focus remains on caring for our veterans.

Ms. WALORSKI. Ms. Mooney——

Ms. MOONEY. We want to make——

Ms. WALORSKI. Let me interrupt.

Ms. MOONEY [continuing]. Absolutely sure——

Ms. WALORSKI. Listen to me. Ms. Mooney, this is my time that I have, a limited time.

I have sat here for 18 months as a freshman. I have gotten very few answers to any question I have ever posed to you or anybody else. I am still waiting on questions about a South Bend CBOC in South Bend, Indiana, to serve my veterans.

Ms. MOONEY. Congresswoman——

Ms. WALORSKI. Mr. Huff, do you share this responsibility? Does the buck stop with you?

Mr. HUFF. Congresswoman, I am a——

Ms. WALORSKI. Yes or no.

Mr. HUFF. I am a staff-level——

Ms. WALORSKI. Does the buck stop with anybody——

Mr. HUFF [continuing]. Congressional relations officer who is a civil servant and, also, a veteran. I am not a supervisor. I am a staff-level Federal employee, and I do the best job I can.

Ms. WALORSKI. Mr. Huff, does the responsibility lie with Secretary Shinseki? Do you still believe in his leadership ability to stand up to a five-alarm fire? Where in the world is the urgency?

I can sense the urgency of this committee, Democrats and Republicans, because our Nation has totally lost its trust. It is our responsibility to sit here and continue to maintain oversight, and we can't find out where the buck stops.

I have asked for Secretary Shinseki's resignation when the American Legion report came out. You have heard several different people asking the question: Does the buck stop with you?

Do you accept this responsibility? Are you ready to accept this responsibility and look in the eyes of the American people and our veterans and say—what? What do you say tonight?

I know what you don't know. What do you know that you can tell the American people that they can learn in 2½ hours of a committee meeting?

Ms. MOONEY. Congresswoman, our focus remains on caring for these veterans. We join you in this——

Ms. WALORSKI. If that is the case, Ms. Mooney——

Ms. MOONEY. May I finish?

Ms. WALORKSI. No. Because I have 5 minutes.

Ms. Mooney, if that has been the case, how could Dr. Lynch go to Arizona and not talk to anybody involved that had anything directly to do with this and there is 40 unexplained deaths, there is an IG report that has facts and you all seem to have turned the facts to a general counsel and we know less tonight?

I have more questions tonight than I have had when I walked in here because we learned what you don't know.

But my question is—and it is going to have to go unanswered—what do you know? Here is what we know.

Ms. MOONEY. We know that the facts of that report are utterly reprehensible. That is what we know. And we owe a debt to all our veterans who served, every one of them.

Ms. WALORSKI. So are you responsible?

Ms. MOONEY. I will take the responsibility.

Ms. WALORSKI. Do you take that responsibility?

Ms. MOONEY. Absolutely.

Ms. WALORSKI. What are you going to do with that responsibility? Are you going to stay in your position? Are you going to apologize? Are you going to resign? Are you going to ask——

Ms. MOONEY. I am going to stay in my position and fight for veterans and fight for this Congress that I love, working together and really meaning it, working together for the good of our veterans. That is what the public expects, and that is what I am committed to.

Ms. WALORSKI. And look what the public got. The public got—and 40 veterans died. This is what the public got.

Ms. MOONEY. And we understand that, and we view that report as totally—the facts of the report as totally reprehensible, inexcusable, unconscionable.

The CHAIRMAN. Gentlelady's time has expired.

Thank you, Ms. Mooney.

Ms. WALORSKI. Thank you.

The CHAIRMAN. Ms. Jackson Lee, you are recognized for 5 minutes.

Ms. JACKSON LEE. Chairman and ranking member and members of this committee, thank you for the courtesy. But, also, thank you for the service that you are doing for the American people and for all of the veterans.

There is probably not one of us that could not count our relatives—four uncles in World War II, thereafter for me, and others' extended family members, neighbors, faith members and others—there is not a place that we can go that we do not touch a veteran or a veteran does not touch us or soldier.

And, as well, there is not a place where we can go where we are not grateful that they have served and willing to serve.

This is overwhelming. And I thank you for allowing me to sit here. I am from Texas. And there are veteran facilities, including those in my area of 32,000 veterans in the 18th Congressional District alone.

So I want to just read this into the record, which my colleagues who are on this committee have probably immersed themselves in, but I just want to have these words. This is about the scheduling practices reported in Phoenix.

"We are finding that inappropriate scheduling practices are a systemic problem nationwide." And then just to read this paragraph: "Schedulers go into the scheduling program, find an open appointment, ask the veteran if that appointment would be acceptable"—and they call it Scheduling Scheme Number 1—"back out of the scheduling program and into the open appointment date as the veteran's desired date of care. This makes the wait time of an established patient 0 days."

My question is: Where is the focus now with this report saying that this is systemic, this is nationwide? And I have heard you say that there is a nationwide audit.

But the question is: While we are having a nationwide audit—and many of us have sent letters. And I guess I should ask the question first. I have sent a letter about the VA Hospital in the 18th Congressional District or in the neighborhood, which is in Houston, Texas.

How soon will Members of Congress individually—there could be 435; there could be 535 letters—be able to get our responses to know the crisis in our own neighborhood? How soon could we get that response?

Ms. MOONEY. Do you want to——

Dr. LYNCH. I am sorry. Hopefully, as soon as it is available, Congresswoman.

Ms. MOONEY. Yeah. We are looking to brief the Congress as soon as it is available.

Ms. JACKSON LEE. But if we are sending our letters and we want to know about our immediate crisis in our own neighborhood, how soon can we get that response? I didn't realize there were 700 lawyers. But is it——

Ms. MOONEY. Congresswoman, it will be forthcoming very, very soon. I know the results of the audit are being compiled now, and we look forward to having them out to you.

Ms. JACKSON LEE. But the individual hospital reports, is that how it is coming?

Ms. MOONEY. Yes. Yes.

Ms. JACKSON LEE. Are you separating the requests from Members from your general audit? If a Member sends a letter, can they get an answer immediately?

Ms. MOONEY. I think we are looking to release the audit nationwide at one time. That is my understanding.

Ms. JACKSON LEE. That disturbs me only because, when we are in our districts, we are hearing individual outcries about time. And I want to agree with many Members who have said we have very fine providers in the VA system and we should pay tribute to them.

I know, in particular, Michael E. DeBakey Hospital has a very fine, credible staff who cares, as do others. But I also know that, when I travel around—I have individuals I met in the airport—an individual said that they waited for 4 months for an elderly veteran for service. And when you go and get information directly from these hospitals, they have completely different numbers.

And I guess my concern is what numbers are we to believe in and how—what a crisis we have with it being a nationwide system.

Is there no way to take and have what we would call task forces or special ops in the veterans to target into places besides just having an audit to be able to go into hospitals and fix problems quickly, a SWAT team of sorts?

Dr. LYNCH. Congresswoman, we have right now at the same time that the audit is going on facilities identifying patients on the wait list. We are identifying those facilities that are challenged in terms of clinic efficiency.

We are looking at ways of providing care to veterans in a timely fashion using non-VA care, and we'll be helping those facilities that need assistance in providing more efficient care processes. That is going on simultaneously with the audit.

Ms. JACKSON LEE. Let me just finish on this note, because I appreciate the passion. You all are public servants.

Can we please get the kind of stated outcry from the leadership of the Veterans Affairs Department standing up, claiming responsibility, speaking not to us as Members of Congress, but speaking to these veterans, that, "We are prepared and ready, one, to criminally prosecute those who may have been in a coverup"—I am not saying a witch hunt—and then, secondarily, standing up and saying, "We are pained by what is happening and, veterans of the United States of America, we will not rest until we finish this task on your behalf and save your lives and provide you with care"? Can we hear that?

Ms. MOONEY. Congresswoman, we will not rest and we have not rested. We will not rest until we provide veterans with care.

Dr. LYNCH. Congresswoman, we have been working to identify and understand the problem across our entire system and to initiate solutions so that we can eliminate wait times and get veterans care when they need it as soon as possible.

Ms. JACKSON LEE. I thank the chairman for his courtesies and the ranking member for your courtesies.

The CHAIRMAN. Thank you.

Mr. Jolly, you are recognized for 5 minutes.

Mr. JOLLY. Thank you, Mr. Chairman. I appreciate the understanding and courtesy of the chair.

I had an amendment on the Floor this evening. I apologize. I have missed some of this. I will tell you my line of questioning. If there are areas that have already gone on the record, just feel free to point me to the record. I know it is getting late.

I believe that the Department and this Congress ultimately can identify long-term institutional reforms. I think we can get through that. Those are long-term institutional reforms, though. My concern is what is happening immediately right now to clear the wait list.

Dr. Lynch, you mentioned that, by Friday, everybody at Arizona will be contacted and, in your words, if needed, be referred out, fee'd out.

My understanding—and the question is—please correct me if I am wrong, in the first place. And, secondly, I will give you my question.

My understanding is that is the current policy, that if a veteran—if it is determined a veteran needs to go outside the system, that can actually occur now.

Dr. LYNCH. Congressman, if the veteran requests care, we will refer him when we speak with him.

Mr. JOLLY. Well, in practice. So—and I will tell you I have sat with my own hospital administrator in my district. And I understand, in practice, the hurdles that are required when that veteran requests to go outside of the system. It is actually not an easy task, in fact.

Dr. LYNCH. There will not be hurdles, Congressman. We are committed to getting veterans who are on the wait list care as they—you know, as appropriately and efficiently and as soon as they need it.

Mr. JOLLY. Right.

So my question is: The current policy is already, if it is needed, non-VA care is available. If we are saying now the standard for this Friday deadline is, if it is needed, a veteran can go out, how is that any different, other than you are just suggesting the Department's going to try harder?

And, secondly, how is that need evaluated? I understand a call center in Kansas. But is that need a medical evaluation?

Dr. LYNCH. That is going to be a conversation with the veteran. If there is need for a medical assessment, we will have a call center medical professional or a provider or a nurse professional available to discuss the patient's care and to determine the acuity of his need.

Mr. JOLLY. Is the standard of review going to be any more relaxed than it currently is?

Dr. LYNCH. Congressman, it is my understanding that we are going to get these veterans care in the community.

Mr. JOLLY. So I will tell you this is surprising to me. And I have talked about this every step of the way. I don't think this is a political issue.

As I said at the beginning, I think that Congress and the administration can get to the bottom of long-term institutional reforms.

My concern is the Department currently has the authority—I know you have probably heard it a dozen times tonight—the Secretary has the authority to refer people out. You are currently indicating you are going to do that by Friday.

You are asking us to trust, however, that the same administration executing the same exact policy, the if-needed policy that was already in place, is somehow going to have a different result in the next 48 hours.

And I will tell you this. If so, I will be the first one to go to the well of the House and compliment the administration and the President of the United States because I think this goes all the way to the desk of the President of the United States.

Thus far, though, we have not seen an indication of new policies, new programs, emergency measures, new personnel. Really, your only indication tonight is that you are just going to try harder and put a call center in Kansas, but apply the same if-needed standard that already exists.

Dr. LYNCH. No. Congressman, let me go a little bit further, if I may.

Mr. JOLLY. Please do.

Dr. LYNCH. With respect to Phoenix, they have already approved the hiring of 12 more physicians. Three of those will be online shortly.

We have approved and we have brought on board a number of new schedulers to increase the efficiency of the management of scheduling from the wait list.

We will be moving locum providers to Phoenix as well as mobile medical care centers to try to improve capacity and capital resources to provide that care.

We are taking steps to increase capacity and services in Phoenix. If we can provide care to veterans who have been identified by the IG in Phoenix in a timely fashion, we will. If we cannot do that, they will be sent to the community for care.

Mr. JOLLY. And you indicated other facilities as well would be undergoing a similar review?

Dr. LYNCH. Right now, VA is collecting—or has asked each of our facilities to identify patients who are currently on their wait list, who are waiting for care, to give us that list so we know the numbers. We are going to assess if we can provide that care locally. If we cannot, we will move that into the community.

Mr. JOLLY. I appreciate the response.

And I would just express my concern for the record, and it is this: It is the very same medical doctors, physicians, medical staff that have already determined that these patients don't need to go outside of the system for non-VA care that we are now asking to reconsider whether or not they do.

And without a dramatic shift in the administrative judgment that you can expect every one of your medical providers to exercise in this new 48-hour period, I still have great concern that it is not going to solve it.

But I very much appreciate that measures are being taken and I hope they are successful.

Mr. Chairman, I yield back. Thank you.

The CHAIRMAN. Thank you very much, Mr. Jolly.

Everybody obviously continues to have a heightened interest in talking with our witnesses. We have had numerous requests for a second round. The chair will give a second round of questions.

But, with that, I ask unanimous consent that we have a 5-minute recess. And we will reconvene in 5 minutes.

[Recess.]

The CHAIRMAN. Hearing will reconvene.

Dr. Lynch, if you would, I am going to read you from the April 9 hearing here in this room.

And, basically, I asked you: "Does the VA have every legal authority it needs to pay for a veteran's care whose care is delayed to receive care outside of the VA system?"

Your response: "To my knowledge, sir, yes."

I followed up: "So would it be correct to say that failure to deliver care in a timely fashion is simply a question of poor leadership at VA?"

Your response: "I think that would be a stretch, sir. I think that our system strives to treat patients within VHA because we think we do provide good care. We think we provide quality care."

Could you please expand on that, now that you have had several weeks to reflect.

Dr. LYNCH. Congressman, I still think we have a good system, and I think we have evidence that we deliver good care.

We are obviously in very difficult times right now. We have identified that we have significant failures to provide timely care. We need to address that.

I think we have a way forward. I think we have the tools to do that. I think it is going to require the collaborative relationship with Congress and with your committee.

And I think, sir, I have demonstrated in the past I am willing to work with your committee to try to identify problems and to look to solutions.

The CHAIRMAN. Thank you very much for your response.

I would also ask: Do you think, though, that this has been a failure of leadership or what has it been?

Dr. LYNCH. I think that there is the potential that we have lost true north. I think we need to focus on our mission, treating veterans, providing health care. I think we need to focus our performance measures on giving us the tools that we need to provide timely care, Mr. Congressman.

The CHAIRMAN. Thank you very much.

And the letter we received from Mr. Gunn dated May 27 basically says that these were the remainder of the documents identified in our search of the 27 custodians. In other words, the general counsel believes that they have complied with the subpoena.

Ms. Mooney, would you deliver a message back to the general counsel that the committee says that the VA has not complied with the subpoena? Would you do that for us?

Ms. MOONEY. Yes, sir.

The CHAIRMAN. Ms. Mooney, on September 13 of 2013, the committee requested the current status of all VA health care facilities that have an appointment wait time backlog. To date, we have received incomplete information on only two of hundreds of VA medical facilities.

Now, despite this request being over 8 months late, when can we expect to receive a response?

Ms. MOONEY. Congressman, we will work to get you that request as expeditiously as possible.

The CHAIRMAN. 8 more months?

Ms. MOONEY. No, sir. We look to having the results of the audit and getting the response as quickly as possible.

The CHAIRMAN. But this—okay.

Ms. MOONEY. I don't know the circumstances of this particular request, but we are—we will work to get that.

The CHAIRMAN. Will the——

Ms. MOONEY. And we'll take that back and make it the committee's top priority, if that is what you indicate.

The CHAIRMAN. Thank you very much.

The committee sends a letter every week to the Secretary with every single outstanding request. On January 6, 2014, VA was sent a request for information regarding gastrointestinal consult delays for each VA health care facility. To date, we have received no response.

When will we receive a response?

Ms. MOONEY. On consult delays, I will have to—I will get that information for you as to when we can provide it.

The CHAIRMAN. On January 14, 2014, a request was sent to VA asking for a copy of a report that contained information on consult delays all across VA medical facilities and for complete consult delay information from 2005 to present.

Considering that this request is over 4 months late, when will we receive a response from you?

Ms. MOONEY. Congressman, I will—or, Mr. Chairman, I will work to get you the information and look into that request immediately as one of the priorities of the committee.

The CHAIRMAN. Ms. Mooney, to date, have you provided any information to the committee staff to explain when the alternate Phoenix wait list was destroyed?

On April 28 and 29, the staff asked Mr. Huff. No response. On April 30, the staff called and asked you. No response. On May 1, I wrote a letter to the Secretary. No response. Hence, the committee's subpoena on May 8.

It seems pretty simple. There was a list. The list was destroyed. We asked when was it destroyed, and you still have not provided an answer despite nearly a month of time elapsing.

Mr. Michaud, you are recognized.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Mr. Lynch, getting back to waiting lists and your response to Mr. Jolly's questions about fee-for-service, is that primarily just for the Phoenix, Arizona, facility or is it throughout the VA, in general?

Dr. LYNCH. No, Congressman. As we evaluate the wait list from all of our facilities, we are going to be determining how we can effectively use fee-basis services to reduce and eliminate those wait lists.

Mr. MICHAUD. Throughout the system?

Dr. LYNCH. Throughout the system.

Mr. MICHAUD. I am very glad to hear that.

My big concern is, if you look at some of the other problems the VA is going to be facing with long-term care needs for our World War II veterans and Vietnam veterans as well as when the drawdawn occurs over in Afghanistan, there is going to be a huge need for services from the VA and the VA cannot provide all those services and you do have to look at fee-based services. The fact that 40 percent of our veterans live in rural areas that—I think we definitely have to look at that problem there.

My question is to Ms. Mooney. I know you talked about, you know, you can't answer some questions because it is in general counsel. But as has been stated earlier, we only went the subpoena route when we could not get the information in the first place. That was very narrow and very specific to Phoenix. And I know the VA—every time we ask for information you talk about the long list of questions that we are asking, and we try to make your job a lot easier.

When Sloan Gibson was before this committee, the Deputy Secretary, we talked to him about the fact, to help speed up the process, we asked that the VA allow committee staff or Members of Congress, if they want to talk to subject matter experts, that we can do that so, that way, you will not have to respond to letter from us. But, yet, that seems to still be a problem.

And we are trying to work with you, but there has been a disconnect between what this committee needs to do our job for oversight and what the VA is willing to give us.

And the fact that we can't speed up the process by allowing subject matter experts to work directly with the committee staff when asked rather than having to go through OCLA is part of the problem when you look at the frustration that we see here, you know, as a committee.

And, hopefully, we'll be able to address those particular concerns and problems that we have within the system.

And I will ask you once again: Would you allow the subject matter experts to talk to committee staff without having to go get approval through OCLA?

Ms. MOONEY. Congressman, I think, as you know, Dr. Lynch came to the committee to brief the committee and the committee staff and to engage in conversation with them. I understand. I understand the frustration on the point of wanting us to reaffirm.

Again, Dr. Lynch did not provide——

Mr. MICHAUD. Well, Ms. Mooney, yes. I mean, that is the VA deciding who is to come to us. I can give you examples where legislators ask the subject matter expert whether or not they can come brief us on certain issues. They said they were willing to, but they have to go through OCLA to get OCLA's permission.

Ms. MOONEY. No. I would respectfully suggest it is not permission. We look to coordinate and take——

Mr. MICHAUD. We have an email and we'll gladly share it with you, Ms. Mooney, from a subject matter expert saying that is the policy of the VA. Now, we can address that.

I have brought it to Sloan Gibson's attention. I have talked to the Secretary a number of times about the fact that the relationship between the Department and this committee is getting extremely

strained because we are not able to get the information that we need to.

We tried at the beginning of my term as ranking member to smooth out some of the requests as far as going directly to the subject matter expert. That has not worked. And so, hopefully, we'll be able to get that working the way it should be working to build up trust and open line of communication.

Mr. Huff, I want to thank you, first of all, for your service. And I know that you are the congressional relation officer. You just happened to be in the meeting with Dr. Lynch, and that is why you are appearing here today.

I want to thank you for your service. I know that you are not in the position where you actually have to make these decisions. That is above your pay grade.

And I do want to thank you for your willingness to come this evening to talk to us here on this committee. And I do understand that these are above your pay grade.

So thank you for coming forward and answering the questions that were put to you this evening, and thank you for your service.

With that, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you.

Mr. Lamborn for 5 minutes.

Mr. LAMBORN. Thank you, Mr. Chairman.

In the Interim Inspector General's report, I want to ask you about a couple of things.

First of all, on page 3 and 4 of the executive summary, there is this statement: "We are not reporting the results of our clinical reviews in this interim report on whether any delay in scheduling a primary care appointment resulted in a delay in diagnosis or treatment, particularly for those veterans who died while on a waiting list. The assessments needed to draw any conclusions require analysis of VA and non-VA medical records, death certificates and autopsy results. We have made requests to appropriate State agencies and have issued subpoenas to obtain non-VA medical records."

How many subpoenas do you know that the—has the IG's office issued to non-VA agencies concerning deaths of people on a waiting list?

Dr. LYNCH. I don't know, Congressman.

Mr. LAMBORN. Okay. Do you happen to know—have they contacted the VA about VA medical records, death certificates or autopsies?

Dr. LYNCH. I am sure they have.

Mr. LAMBORN. Do you know the specifics?

Dr. LYNCH. I don't know the specifics.

Mr. LAMBORN. But they are carrying out that part of the investigation?

Dr. LYNCH. Congressman, to the best of my knowledge, the IG is taking this very seriously and making an honest attempt to understand the deaths and to determine whether or not they were related to the delay or not. I think that is a critical question——

Mr. LAMBORN. Absolutely.

Dr. LYNCH.—you need to understand.

And I think it is such a critical question that they are doing this very carefully. They want to be right the first time.

Mr. LAMBORN. Absolutely. We all want that.

When will they be done?

Dr. LYNCH. I don't know.

Mr. LAMBORN. Okay. Let me change subjects—because my time is limited—and ask about Recommendation Number 3 in the report. Tell me if you agree with it.

It says, "We recommend the VA Secretary initiate a nationwide review of veterans on wait lists to ensure that veterans are seen in an appropriate time, given their clinical condition."

Dr. LYNCH. I agree with it. And it has been implemented.

Mr. LAMBORN. Okay. My question, then, is this. Let's say Fort Collins for the sake of example. You contact them and say, "How many people are on your waiting list?" And they have a secret waiting list. How can you rely on their answer?

Dr. LYNCH. Congressman, I think, number one, we have the assistance of the IG to help us to assure that we are establishing integrity in our system.

Secondly, I think that we are looking very carefully. We are encouraging employees to anonymously report and to identify where they think there have been secret wait lists or where they have been told to do things that are not part of our policy.

Mr. LAMBORN. The procedure you said you would use for the 1,700 in Phoenix to get them immediate treatment, especially if they have gone on too long without getting it, using fee basis, as myself and others have asked you about, will that be used elsewhere in the country or is that exclusive to Phoenix?

Dr. LYNCH. No, sir. It is not exclusive to Phoenix. If the facilities cannot provide timely care to patients on the wait list, we will be using fee basis to provide that care.

Mr. LAMBORN. Okay. I am really glad to hear that because I have almost 100,000 veterans in my district, in California Springs, and we are getting a lot of concerned phone calls, as you can imagine.

So I would urge you, especially because the projection is $450 million—almost half a billion is going to be turned back from the VA—or rolled over until next year—let's use that money. Let's consider this a disaster relief for veterans.

Dr. LYNCH. Congressman, we have to reestablish credibility in VA. This is critical. We take this very seriously. No veteran should be harmed because of delay in care.

We need to resolve this problem. We have a good health care system. We have to assure that veterans have access to that good health care system.

Mr. LAMBORN. And when will this nationwide review be done?

Dr. LYNCH. I believe it is going to be completed in the next week or so. There was a new round. The Secretary requested that all facilities be evaluated, not just the larger facilities. So I don't know the exact date of the conclusion.

Mr. LAMBORN. Well, I agree with the intention behind it, but I still have the concern.

Can we rely on their self-reporting to you when some of these people are hiding information? Will they be up-front with you?

Dr. LYNCH. I think, Congressman, that it is not only our audit. I think we have the IG assisting us. I think we have the resources

to identify where there are vulnerabilities in our system. We have to do that. We have to restore the credibility.

Mr. LAMBORN. Absolutely. Thank you.

And, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you.

Ms. Brown, you are recognized for 5 minutes.

Ms. BROWN. Thank you.

First of all, let me thank all three of you for your service. Thank you very much. Because I think it is very important that we have veterans working in the Veterans Administration that is committed to veterans.

And, by the way, Ms. Mooney, how many veterans work in the VA system?

Ms. MOONEY. About a third of our employees are veterans. And I am very proud that half of my workforce in OCLA are veterans. And many more are family members of veterans as well. We all care very deeply about our mission.

Ms. BROWN. Thank you.

Now, the fee-for-service—there has been a lot of discussions about the fee-for-service, and we have had that available.

Part of the reason why a lot of veterans don't want the fee-for-service is they want their care in the VA and they have come to the committee over and over and over and told us that they want the services in the VA.

And, in fact, I know it—you know, being on this committee for 22 years, I know there is not a lot of institutional memory, but I do have a little bit here.

And on January 16, 2003, the Bush Administration just stopped taking the priority 8 requests for services. On June 15, 2009, Secretary Shinseki opened it back up and let all those veterans come in. So that was millions of—millions of veterans that didn't have to prove their individual case, which is what was needed, but it also wasn't great to the system.

Now, how can we—and I am trying to take it a step further—how can we work with the community? Because I don't think the VA needs to hire 100 new people or thousands of new people.

How can we work with the community groups that is already doing it? One of the areas, mental health, a lot of them need—it is not just that they are homeless. They need comprehensive care.

How can we work closely with communities to provide the veterans what they need? It is not just a list. It is making sure that they get the services they need off the list.

Dr. LYNCH. Congresswoman, the VA has been holding summits for the past 2 years now, to the best of my knowledge, where we involve community providers in understanding what our mental health needs are and engaging them in participating in the mental health care of veterans.

Ms. BROWN. Do you want to speak to that, Ms. Mooney?

Ms. MOONEY. Additionally, I would just echo many of you saw the Senate hearing last week where we had our veterans service organizations make statements that the simple truth is VA is the best health care provider for veterans.

In fact, VA specialized services are incomparable resources that can't be duplicated in the private sector. That is from Carl Blake from the Paralyzed Veterans of America.

In AMVETS, they said the same thing: Let's not throw out one of the premier health care systems in the world in our haste to fix these problems or achieve political goals.

Commander Dellinger of the American Legion noted that private care can help get money more quickly, but, "We have to put a caveat on that." It can't happen exceedingly because there goes the entire budget. And it's fee-based, which is going to be higher in the private sector versus the ability in VA.

I know for myself, Congresswoman, for loved ones that I have had who have sought care in the community, while great and well intended, did not meet the same transformative care that they received in VA that was life changing for them and for our entire family.

Ms. BROWN. And I agree with you. And there has been lots of accusations based on whether or not—how many people have died in the system. Those are allegations that is being investigated.

And, you know, I just really have a problem when I listen to the television or—you know, the "Scandal"—the "Scandal." Listen, this has been a scandal for VA for years, and finally we are getting the finances and the services that we need.

We have forwarded budget. Someone says, "Why do you turn this money back?" No. We are not doing it like the other agency used to do it. You have got to spend it by the end of the year or else and you just buy gidgets and gadgets.

What we have now is we have that money for next year so we can continue to work with veterans to make sure that they get the services that they need.

Would you speak to that. I mean, because that was something I think that was very important.

The CHAIRMAN. Gentlelady's time is 2 seconds from expiring.

Gentlelady's time is expired.

Mr. Bilirakis, you're recognized 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much. With regard to Dr. Lynch, define timely care, because you said that the vets who are on the waiting list that had to wait a long period of time, that they'll be able to go outside the system to receive the care. Define, what's your definition of timely?

Dr. LYNCH. Right now, if somebody goes on the waiting list if we cannot provide care within 90 days of the request. Ideally, we would like to provide care more timely. I think even outside of——

Mr. BILIRAKIS. Ninety days is a long time.

Dr. LYNCH. Ninety days is a long time, Congressman.

Mr. BILIRAKIS. Okay. With regard to the regards, are you aware that in the fiscal year 2013, the Department was found to be at high risk regarding record management obligations by the National Archives Records Administration. Are you aware of that?

Dr. LYNCH. I was not aware, Congressman.

Mr. BILIRAKIS. If you're not aware, does anyone else on the panel? Ms. Mooney, are you aware of that?

Ms. MOONEY. I'm sorry, the question was again, sir?

Mr. BILIRAKIS. The Department was found to be high risk regarding records management obligations. Are you aware of that, the VA in 2013?

Ms. MOONEY. No, sir.

Mr. BILIRAKIS. Can you please provide me, Dr. Lynch and Ms. Mooney, please provide the committee with actions that the VA has taken since this finding to correct the records management practices? You can provide that information to me and maybe to the chairman of the committee, the entire panel if they wish.

Dr. LYNCH. We'll do our best, Congressman.

Mr. BILIRAKIS. Please. Please do. Thank you very much. Okay.

With regard to the list again, how and when did you become aware of the list?

Dr. LYNCH. I initially became aware of the list when I was in Phoenix on Holy Thursday. Actually, I take that back. It was the Monday following Easter. We were talking, I was talking with Dr. Mike Davies, and he indicated that his conversations with the staff in scheduling had indicated that there was an intermediate work product that was being used to provide the names of veterans.

Mr. BILIRAKIS. Did he create the list?

Dr. LYNCH. Did who create the list?

Mr. BILIRAKIS. The doctor you're speaking of.

Dr. LYNCH. No. The list was created by VistA, which is the VA's health information system. When an appointment is cancelled, as part of that cancellation process, the list of the patients who are cancelled is provided and is printed out so that it can be used to assure that those patients are rescheduled.

Mr. BILIRAKIS. Okay. After the list was created, who made comments or notes on its contents, and what did those notes or comments state? Can you briefly describe it.

Dr. LYNCH. I don't know whether there were any notes or comments on the list.

Mr. BILIRAKIS. How many people was the list circulated to? Do you have any idea?

Dr. LYNCH. I don't know, Congressman.

Mr. BILIRAKIS. Well, can you get that information to us?

Dr. LYNCH. I can try. I can ask in Phoenix if we can identify that. I can't promise you we can get that information.

Mr. BILIRAKIS. Okay. Well, please try to get it to us. I think it's very important, very relevant.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Mr. Takano, you're recognized for 5 minutes.

Mr. TAKANO. Thank you, Mr. Chairman.

I know you get whipsawed back and forth by different members who feel this urgency to get answers.

You state, Ms. Mooney, that you think the audit might be complete within weeks, a week or two?

Ms. MOONEY. Yes.

Mr. TAKANO. My questions to you may seem a little perverse, but how can you get the audit done so quickly, given the scale of the Department? Is that a realistic turnaround time for you?

Dr. LYNCH. Congressman, maybe I'll try to answer that based on what I know about the audits. VA has mobilized resources from across our system. We have asked each of the networks and facili-

ties to provide volunteers to do these audits, to go out and evaluate hospitals so that we can get this audit completed in a timely fashion.

Mr. TAKANO. Again, I go back to this issue of how good this information is that you're getting from people. I mean, the public officials have called for criminal investigations or turn this over to the Justice Department. Are people going to lawyer up, clam up? Is that going to slow down the ability to get information out of people.

Dr. LYNCH. I am sure that there are people who are concerned. I think that the IG is also our partner in this. They have also been evaluating facilities, particularly those with concerns. They have authorities that we don't have to obtain the information we need to assure that we reestablish the integrity of our system.

Mr. TAKANO. It seemed as if you did concede that the things were turned into goals. I forget what you said, that you put goals ahead of everything else. I forget the term.

Dr. LYNCH. I think what I said is that we need to focus on our primary goal and responsibility, and that is assuring timely care to veterans, that is giving veterans access to our system and providing quality care.

Mr. TAKANO. I thought Mr. Flores' line of questioning was really enlightening when he brought up the case of Enron, that maybe the incentives that were built into the management of the VA in the health system induced some of the results that we have seen today.

Dr. LYNCH. Congressman, I think that's possible. I think that's what happens when measures become goals.

Mr. TAKANO. Well, in the situation we're in now, I'm concerned less about the rewards that—or the incentives that might have led us to this point. I'm concerned about the amount of time it's going to take to get a good, accurate audit and that maybe the punitive atmosphere may also impede that. That's where I'm really going with my line of questioning, is the sense of the punitive instinct going to cause us to see an audit that may be less than whole?

Dr. LYNCH. I can tell you, Congressman, that we have discovered system failures as part of our audit. I don't think that our audit is going to be a whitewash. I think we are identifying some of the same concerns that the IG has identified.

Mr. TAKANO. Real quickly, is there a shortage of providers? Is that within the system in these particular areas where we have seen failure, is that a large part of what the problem is?

Dr. LYNCH. There are some facilities where there is a shortage of providers. To Congressman Wenstrup's point, I think there are things we can do to increase the efficiency of our providers. I suspect he would agree with me that in the private sector, we can provide support services that make physicians more efficient so that they can see more patients. There could be simpler solutions than hiring physicians. There could be solutions, such as hiring support so that physicians can see more patients, providing them additional rooms so that they can work more efficiently. I think it's not just the provider. It's the support we give the provider so that they can work efficiently.

Mr. TAKANO. This fee for service, I mean, I applaud your effort to simultaneously try to get these 1,700 people seen by providers,

but I'm a little worried about the systemic consequences of that. Are fee for service, are they sufficient for physicians in the private sector to take on these patients?

Dr. LYNCH. There are some communities where we do not have sufficient fee providers, and we're going to have to look at how we are going to address capacity issues at these VA facilities so that we can treat those patients in a timely fashion. It's a complicated process. We have to assess how efficiently we're working, how efficiently we're allowing our physicians to work, and what's available in the community.

Mr. TAKANO. Thank you.

I'm sorry for going over, Mr. Chairman.

The CHAIRMAN. Thank you.

Dr. Roe, you're recognized for 5 minutes.

Mr. ROE. I do want to say that the Mountain Home facility in Johnson City, Tennessee, there have been a lot of letters to the editor recently have all been positive. There are a lot of positive things that go on with the VA. I want to get that out there.

Secondly, I remember asking the Secretary every time I've been here now through six budgets, do you have the resources you need to carry out your mission to take care of American veterans, and the answer has been yes every time. Something's wrong if the answer is yes. And the question I have very quickly, in Phoenix, what happened? And I can tell you flatly how to make the doctors more efficient. Right now, you've got physicians in the VA system that are clerks. They have to call and schedule all appointments. They have to do all the data entry. They have to do all those things. Let me tell you, that slows you down enormously when you have to do that. You could hire somebody just to put the information in electronic health record and about double the capacity or a 50 percent increase in any physician because it slowed me down about that much when I got the electronic health record. I can tell you in 2 seconds how to make it happen, how to make the doctors. But in Phoenix specifically, when you had people calling in, look, I understood when more people called into my office that we couldn't see, we needed more providers because we were as efficient as we could possibly be.

And right now, I mean, Ms. Mooney, you made the comment in my home town in orthopedic surgery, the doctors operating on people in the VA were in private practice and got toward the end of their careers and got tired of fooling with all the stuff that's going on and went to the VA. They're very fine physicians, but they were very fine physicians the day before.

And I think I heard Dr. Lynch just say that in 90 days, if you didn't get taken care of, we'd get you out in the private sector. Are you saying today that if I have a veteran with a bad knee that needs to be replaced and it's not fixed in 90 days at the VA, that we can get that veteran out in the private sector and get his or her knee or hip or back fixed or whatever they need done, because it ain't happening right now?

Dr. LYNCH. Congressman, I think it depends on eligibility, but I think we have the option to try to do things more efficiently.

Mr. ROE. I think you said in 90 days if the veteran didn't have an appointment taken care of, I think that's what I heard you say,

then I'm going to go back home and when a veteran comes up to me and says, I've got assurances from the VA that you can get your knee or your hip fixed in 90 days, because we can do that in the private sector right now today.

Dr. LYNCH. Congressman, within the limits of eligibility, we hope to get that done.

Mr. ROE. Well, no, that's not what you said a minute ago. You said we're going to do that.

Dr. LYNCH. Congressman, we are going to get that done within the limits of eligibility.

Mr. ROE. What happens this summer, in August, when I go home and I enter the August recess, and the veterans are not getting taken care of; they're having to wait 6 months or a year or 18 months, which they are now, to get a hip or knee replaced?

Dr. LYNCH. Then I hope you'll let me know so I can look into it, Congressman, if that's happening.

Mr. ROE. That's not what you said. You said we'll take care of it in 90 days.

Dr. LYNCH. I'm saying if that hasn't happened, I want to know about it so I can identify the problem and fix it because the delay should not have occurred.

Mr. ROE. The problem in Phoenix is, I'm trying to get my arms around it. What was the problem there? I realize all the lists and destroyed lists. What was the reason that these veterans couldn't get in? Nobody's even said that tonight after 2 hours.

Dr. LYNCH. Congressman, I think part of the reason was capacity and their ability to see patients in their system. It appears that they needed more physicians, care working with them to identify more physicians. There was probably an inefficient process of handling patient requests. I don't think they had enough personnel in their scheduling area to get patients on the wait list and to get them scheduled.

Mr. ROE. If, at the VA there, let's say any system in the country, if those, and it's been sort of danced around a little bit here tonight, but if a VA system is turfing out or sending out into the private sector, a fair amount of people, how does that effect the bonus of the people running the VISN and the local medical center? In other words, that is one—we know that scheduling time, we have learned that's one thing, but is that something else that affects their bonus? If I send this veteran out to get care promptly, then it will hurt me financially. Is that true?

Dr. LYNCH. I don't know, Congressman.

Mr. ROE. Well, what metrics are used to determine what bonus is provided for a VA director.

Dr. LYNCH. It varies by network. The network director makes the decision.

Mr. ROE. Each VISN decides how the bonuses are handed out?

Dr. LYNCH. They're going to establish the metrics they think are important for their facilities.

Mr. ROE. Could you get me the criteria for that for how someone is paid a performance bonus in the VA system.

Dr. LYNCH. Congressman, we'll try to get that for you.

Mr. ROE. Will you get it for me?

Ms. MOONEY. Yes, sir.

Mr. ROE. Thank you.

The CHAIRMAN. Ms. Titus, you're recognized for 5 minutes.

Ms. TITUS. Thank you, Mr. Chairman.

Dr. Lynch, you said you went to Phoenix for 6 days and mostly what you did there was try to stay out of the way of the IG. You didn't talk to any doctors, didn't talk to any veterans, didn't talk to any whistleblowers, but you did learn about the procedure. And so we have heard a lot about procedure. We have heard a lot about goals. We have heard a lot about metrics. I'm not sure what all that means, but most of the focus has been on the past. I'm more curious about the future. If you put in reforms on all these problems—you hire more personnel, you bring more doctors, you improve accessibility, you get rid of all these scheduling schemes—how are you going to know if they're working? Are you going to come with a new set of metrics? Are you going to do a whole bunch more audits? Are you going to do anecdotal evidence from interviews? How do we know we're really making progress?

Dr. LYNCH. I think, first of all, Congresswoman, the key is to assure that we have the right goals. If we hold people responsible for the right goals—how many patients are you getting into your system, how satisfied are they with your system—then the performance measures become tools. If you try to game those measures, you lose. If you don't know who's on your electronic wait list and get those patients in and increase the number of patients you're treating, then you lose. We have to set up a system where we know what our priorities and goals are and our metrics are focused on giving us the information that assures that we can achieve those goals, provide increasing care to veterans and quality care to veterans with increasing satisfaction.

Ms. TITUS. Hasn't that been the goal of the VA all along? How is that a different new goal?

Dr. LYNCH. I think where the difference occurred is that in some cases, our performance measures became the goal. And we need to get away from that. We need to use our performance metrics as tools, and we need to focus on our core mission, our core values, which are treating veterans and providing quality services so that we get good patient satisfaction.

Ms. TITUS. Are you going to have some milestones along the way so we'll know that progress is being made? We don't have to wait like 2 years from now until another crisis comes and then we go, oh, sorry those metrics didn't work out so well. We got to get some new metrics now.

Dr. LYNCH. Congresswoman, I think we have the tools right now that allow us to monitor the system, to know about access, to know about consult delays. We need to assure that we have integrity in our data systems, that we're getting accurate information so that we can use those tools to provide assistance to facilities when we see that there are delays, when there is increasing demand.

Ms. TITUS. If you have those tools right now, why aren't you using them?

Dr. LYNCH. The tools have been implemented over the last year. We have been putting those in place. Right now, in certain cases, the information we're getting has been compromised by the data that's being entered into our system. We need to assure that we do

clean up the system; we understand where people are not giving us accurate information; and that we instill in our system a sense of integrity. It begins at the Medical Center. It begins with the VISNs. We have to respect the fact that data is important because if we don't have good data, we can't treat veterans appropriately and timely.

Ms. TITUS. Are you going to have these systems in place at all the facilities, and if you discover problems at, let's say, the Las Vegas Hospital that are similar to Phoenix, are you going to be able to bring in all this new personnel, these new schedulers, these new doctors, do all these major changes at every facility where there's a problem?

Dr. LYNCH. Hopefully, Congresswoman, if we can begin to identify the problems before they become major issues, we can work with the facilities to identify where they may need additional resources or where they may have to institute efficiencies, either in scheduling or in their clinics, to provide greater capacity. I think we can use these tools in one of two ways. We can use them to make decisions whether or not we should be buying the care in the community or whether we should be hiring providers and making that care internally. We can use these measures to ask critical questions. Are your clinics effectively managed? Are you using your personnel effectively? There are a number of ways that once we have this accurate information, we can get beyond the wait list that we have now, we can get to a steady state situation where we identify delays before they become significant and institute actions to assure that they don't become major issues and there aren't delays that result in patient harm.

Ms. TITUS. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Flores, you're recognized for 5 minutes.

Mr. FLORES. Thank you, Mr. Chairman.

I have sort of a philosophical issue I've been dealing with, and it goes back to early 2007—excuse me, 2011, shortly after I was sworn in. My very first dealing with the VA was when I was trying to help a World War II veteran that was trying to get hearing aids, and he had been delayed in getting these hearing aids for somewhere in the neighborhood of 2 years. And finally the way that I was able to help this gentleman is I threatened to take my personal funds and buy this gentleman hearing aids. But then they put out a press release that I did it, and then the VA said, okay, well, we don't want to be embarrassed, so they took care of it. Now, there are a lot of great people in the VA.

And, Dr. Lynch, I think you have been on point. I think maybe the VA has lost its north star a little bit or some people within it, not all of it. I think it's got, you know, thousands of employees that do a great job, but I think we have got some that have let a bad culture corrupt them. And so what we have now is a system where poor performance is not punished, where excellent performance is sometimes not properly rewarded. And if you are one of those that cooks the books, well, you can wind up with a bonus out of that. The outcome was lots of—thousands of veterans were waiting for health care, and some of them died while they were waiting. This brings into focus, how good is a Federal Government bureaucracy—this is the same Federal Government that's spent hundreds of mil-

lions of dollars on a health care Web site that didn't work for months. I think we as Americans need to say, what do we want to do here? If our goal is to take care of veterans, then I think we as Congress need to try to think about other models to do this versus using a huge bureaucracy. Again, if our goal is to take care of veterans, we need to think outside the box on how we do this.

This particular issue ought to be a wake-up call. I mean, here we have got an agency that's really committed to taking care of veterans, but what's going to happen when we have a Federal health care system under Obamacare that's going to have to take care of millions more Americans but still use a Federal bureaucratic structure? I think this is a wake-up call that all Americans need to think about.

Dr. Lynch, I do have a question for you. There were three VA employees that were placed on leave in Phoenix as a result of the IG report that came out today. Do you have any idea of the background behind those folks that were put on leave, I mean about why, and what happens next with these folks?

Dr. LYNCH. I believe in his testimony, and I'm trying to recall, I believe it was before the Senate Veterans Affairs Committee, the inspector general indicated that the employees were placed on leave so that they would not compromise the investigation by their presence.

Mr. FLORES. Mr. Chairman, I have no further questions.

I yield back.

The CHAIRMAN. Thank you.

Ms. Kirkpatrick, you're recognized for five minutes.

Mrs. KIRKPATRICK. I'd like to call our attention to Appendix D of the interim report which we got today. It's the OIG oversight reports on VA patient wait times. We have had 18 reports on patient wait times in 8 years, from 2005 to 2013. And now is the time, so we know there's a problem. We know what the problem is, and now is the time to fix it. I want to go then to——

Dr. LYNCH. Congresswoman, I think we have gotten the message. We know we have a problem. We know we need to fix it.

Mrs. KIRKPATRICK. Dr. Lynch, what I do not want to see in 8 more years, 18 more reports, and we're still dealing with the same problem. That's my point.

Dr. LYNCH. Congresswoman, I don't want to see that either. I think we have a good health care system. I think we have a health care system that veterans value, and it's our responsibility to assure that we fix this problem and get them timely access and don't allow it to destroy the system. The VA offers many unique advantages to veterans. We have to assure they get those advantages. I think it's a solvable problem. I think the VA has solved problems in the past and has been better for the criticism we have received and, with the collaboration of Congress, has come up with models which have actually been exemplary and have been adopted by the private sector.

Mrs. KIRKPATRICK. I just want to call your attention to Appendix E, which is the April 26, 2010, letter about the inappropriate scheduling practices.

Dr. Lynch, when did you find out about that letter; and when you did, what did you do about it?

Dr. LYNCH. I found out about the letter, I believe, when it was presented on NBC news approximately 2 weeks ago—2 or 3 weeks ago. I had not seen it prior to that. It had been issued before I arrived in central office.

Mrs. KIRKPATRICK. Ms. Mooney, when did you first see that April 26, 2010, letter?

Ms. MOONEY. Probably sometime in 2010.

Mrs. KIRKPATRICK. And what did you do about it when you saw it?

Ms. MOONEY. I think, with that, we were all concerned, and VHA looked into it. I mean, there was an obvious reason why Mr. Schoenhard wrote that memo.

Mrs. KIRKPATRICK. I am extremely concerned about that answer. This clearly was sent to all of the directors and the central office in 2010, and nothing was done about it. How can that be?

Dr. LYNCH. Congresswoman, I wasn't there at the time. I can't answer that question. I only became aware of that memo and that letter within the last several weeks.

Mrs. KIRKPATRICK. Let me just say this. Let's make sure that this doesn't happen again.

And, Mr. Chairman and Ranking Member Michaud, I think it's incumbent on this committee to continue our oversight responsibilities until this gets fixed. It is not acceptable that we have 18 reports in 8 years, and we're still dealing with the same problem. And our veterans are not getting the care they need.

And with that, I yield back.

The CHAIRMAN. Thank you very much.

If I may ask one question. You said Dr. Davies, did he accompany you on your trip to Phoenix?

Dr. LYNCH. He was in Phoenix, Mr. Chairman.

The CHAIRMAN. Was he part of your investigation?

Dr. LYNCH. He was part of the initial visit that we made. When I returned a week or so later, I had a different team with me that was specifically focused on looking at the scheduling process.

The CHAIRMAN. And his job now is?

Dr. LYNCH. His job is in systems redesign and working with our access and performance measures.

The CHAIRMAN. So that would be he's in the same position today that he was in 2010, because I'm looking at the memo from William Schoenhard, and it says, For questions, please contact Michael Davies, M.D., Director, VHA Systems Redesign. This is the same person that was on this memo.

Dr. LYNCH. It is, Mr. Chairman.

The CHAIRMAN. Okay. Thank you.

Mr. Denham.

Mr. DENHAM. Thank you, Mr. Chairman.

Ms. Mooney, I'm going to ask the same question that's been asked several times tonight. There are audits ongoing right now in the VA centers in each of our districts today. Is there any reason the VA would not share that information with members of this committee, with Members of the House and Members of the Senate on specifically what's happening in their VA center?

Ms. MOONEY. Congressman, we look forward to sharing that information with members of Congress related to——

Mr. DENHAM. So are you committing that the VA will be sharing that with either public or private briefings with every Member that is requesting one?

Ms. MOONEY. I know, Congressman, that we will be briefing Members of Congress and their staffs on the results of the audit, absolutely.

The CHAIRMAN. Will the gentlemen yield?

Mr. DENHAM. Yes.

The CHAIRMAN. Is it true that Senator Durbin has already received a briefing on Chicago?

Ms. MOONEY. No, I don't think so on the results. I don't know. I don't know.

The CHAIRMAN. You're the Under Secretary for the Office of Congressional Affairs, and you wouldn't know if Senator Durbin already received a briefing on Chicago.

Ms. MOONEY. Here is what I know. I know facilities have not, not to my knowledge or understanding now. What facilities—we will be briefing out facilities as we go.

The CHAIRMAN. I only make the request because I read about it in the media, and so I would find it very disingenuous if a United States Senator has already been briefed on a facility in his State and Members of the House of Representatives are asking for the exact same thing and we can't get it.

And I apologize. I yield back to the gentleman. Thank you for the time.

Mr. DENHAM. Thank you. I look forward to that information as well. As well I've heard that the Palo Alto audit is already complete, so I would expect that I have an immediate briefing this week. I'll be calling your office again later this week if I have not received a briefing before we head back home.

Ms. MOONEY. I look forward to it.

Mr. DENHAM. I want to talk about a couple different cases that came up here. James Pert was a Marine who fought in Vietnam from 1968 to 1970. In his early 60s, James is partially disabled. His exposure to Agent Orange and PTSD led to numerous health problems, and he was suffering from skin cancer. When he moved to Phoenix, he visited the VA in need of cancer screening and was told the wait list to see a VA doctor was 6 to 9 months long, and then he signed up. Is there any reason, Dr. Lynch, that somebody would have to wait 6 to 9 months?

Dr. LYNCH. No one should have to wait 6 to 9 months, Congressman.

Mr. DENHAM. No one should have to. I would agree with you. Is there any way possible that in Phoenix or any other VA system, that somebody would be told by a doctor that it would be a 6 to 9 month wait?

Dr. LYNCH. Congressman, I would hope not, but I don't know the specifics of the case.

Mr. DENHAM. We have been hearing a lot tonight about trying and hoping, and trying and hoping is not solving this problem. Is there any problem with somebody moving to Phoenix from a separate area that they would be denied service because they came from an outside area?

Dr. LYNCH. Congressman, one of the areas that VA does need to work on is how we transfer patients across our system. It's not a seamless transfer, as it should be. We are working on processes to make that better. Ideally, if a veteran is being treated by the VA and moves to Phoenix, we should be able to coordinate that transfer so that he doesn't have to become a new patient in Phoenix.

Mr. DENHAM. Thomas Breen was a 71-year Old Navy veteran from Brooklyn, New York, and when he fell ill, he went to the Phoenix Park VA. His condition was rated as urgent, but he was unable to secure an appointment. Is there any reason that somebody would come to the emergency room at VA, see a doctor, be rated as urgent and then sent home for several months?

Dr. LYNCH. Congressman, I don't have an explanation for that.

Mr. DENHAM. Is there anywhere in the VA system where somebody comes into an emergency room under an urgent condition and they're sent home?

Dr. LYNCH. They should not, Congressman.

Mr. DENHAM. And what is the standard wait time for an urgent claim.

Dr. LYNCH. Ideally, if the patient was considered to be urgent, it would depend on what the urgency was, but certainly he should be seen within 7 days. And if it was truly urgent, the patient should be admitted to the hospital.

Mr. DENHAM. Should be doesn't always solve the problem. After 7 days, is there not a tickler file or some type of file or buzzer that goes off, a red light, that goes off that says, oh, my gosh, this guy was urgent, and it's been 7 days. Maybe somebody should follow up with a phone call. Is there no system like that today?

Dr. LYNCH. In Phoenix, I don't know, Congressman.

Mr. DENHAM. He was admitted initially because of blood in his urination. It says there were no tests that were done. Is there any possible way that somebody could come into an emergency room urinating blood and no tests be done? Is that possible?

Dr. LYNCH. I would find it unusual, but I don't know the specifics of the case. It would be my expectation that there should have been tests done.

Mr. DENHAM. His family has testified several times that they called over and over and over again. Would there be a record of those phone calls?

Dr. LYNCH. I don't know, Congressman.

Mr. DENHAM. You don't know if there would be records? Somebody calls a VA center, and we don't document whether or not they called and what the issue was?

Dr. LYNCH. Congressman, I don't know where he called. I don't know the specifics. Ideally, if he contacted the call center, there should be a record that that call was made.

Mr. DENHAM. Mr. Chairman, I'd ask your indulgence since I yielded so much time. I'll be real quick on my last couple pertaining to this one issue.

The CHAIRMAN. You'll be quick on your last question.

Mr. DENHAM. They waited from September to November.

Mr. Breen died on November 30. Is there any reason why somebody who's waiting on a list, urgent or un-urgent, if they're waiting

on a list, that they wouldn't, the VA would not be notified that somebody passed away?

Dr. LYNCH. I think it would depend on where he passed away. The VA in Phoenix now does have an arrangement with Maricopa County. They do receive a list of all individuals who died in the county so that they can look for any veterans that were on that list.

Mr. DENHAM. And the VA called a week later. That's a good reason to make sure that we know so that you're not upsetting the family that much further after they've waited several months to get a phone call from VA after their father passed away. I would just add that Mr. Breen, his comments to his family were, I've got to go to the VA; that's where servicemen go. That is where we go. You serve your country. You want to go to the VA. I want a world class system for our VA, and I don't want to see any more lives lost in the process.

Dr. LYNCH. I don't either, Congressman.

The CHAIRMAN. Mr. O'Rourke, you're recognized for 5 minutes.

Mr. O'ROURKE. Thank you. Dr. Lynch, one of the important things I think that you have made a commitment to this evening is in your words to restore trust in the integrity of the data that we're receiving. Some good news that we received from the El Paso VHA was that in March of this year, veterans seeking new mental health care appointments waited zero days, which seems remarkable and is exciting, except for everything that we're discussing today and our inability to trust what we're hearing.

I already said earlier that we took it upon ourselves to conduct a scientific survey to find out what the facts were and how long veterans were really waiting in El Paso. Could the VA not employ that same method, and in Phoenix, El Paso, everywhere that you're auditing results right now, could there not be just this one-time audit, but ongoing a continuing survey of the veterans, treating them as customers, finding out about the quality of their experience, and verifying their wait time as they experienced it against what the VA said they waited?

Dr. LYNCH. Congressman, one of the options we have been discussing internally is whether or not we could partner with the Veterans Service Organizations and use their members as resources to identify the kind of service we're providing and where they are experiencing delays. I think there is an opportunity there that clearly needs to be explored further.

Mr. O'ROURKE. I hope you will do that. Another thing that struck me was you were talking about a failure within the VA that resulted from elevating a performance measure into a goal, which could possibly have led to the scandal in Phoenix and other, perhaps other failures in other parts of the VA. If the current performance measures are not working, what are some recommendations that you have for how we measure performance at our VHA system?

Dr. LYNCH. Don't get me wrong. I think we need to have performance measures. I think they need to be tools that help us understand our system, and I think we need to focus on our primary goal, which is, are we seeing veterans? Is our system growing? Are we providing quality care? When those become the goals of the sys-

tem, then you cannot game performance measures. Performance measures become a tool. If you ignore them, then you're actually hurting yourself because you're not growing your system like you're supposed to. And as a director or an administrator, you will fail.

Mr. O'ROURKE. I also appreciate your commitment to do more to listen to providers and try to make their jobs better and make the processes that they undertake more efficient. When we met with providers in El Paso, we heard stories about a doctor having to write a prescription to a veteran to be picked up by a van to be taken to a bus station to be taken by that bus to Albuquerque because we don't have a full service veterans hospital in El Paso. All that obviously could have been done by a frontline clerk, but the processes and procedures within that VHA mandate that he does that, which further depresses his morale and his ability to see the patients that he wants to take care of. So I appreciate the commitment that you've made there as well.

Dr. LYNCH. If I can just comment briefly, I think VA has a real opportunity as an educational institution to be able to recruit physicians who are familiar with our process and our electronic medical record. We have to assure, during the course of that training, that we have a system that is physician friendly. We have to identify those things that are not physician friendly, that interfere with physician effectiveness, so that we can effectively recruit those people who are training in our system, who are familiar with our system. It's a huge opportunity.

Mr. O'ROURKE. When I was running for this office in 2011 and 2012, I met veteran after veteran who told me they couldn't get in to see a mental health provider for the entire year, and this is at the beginning of 2012. They said all appointments have been booked for the entire year. I cannot get in. It's very hard for me to believe, but it has since been confirmed by the data that we have been able to obtain. When I got into the office we asked for a manning table. We found 20 full-time equivalent vacancies. We have been working with the local VA to staff those up, but when we get somebody and we recruit them and we bring them to El Paso, it's difficult to retain them. They don't make as much within that system as they do within in the DOD, as they do in the private sector. Do you have enough resources from Congress to hire and retain the providers that you need to provide the coverage and the care that our veterans have earned?

Dr. LYNCH. Congressman, if we don't, I will be the first one to come back and let this committee know.

Mr. O'ROURKE. You're saying you do today?

Dr. LYNCH. Pardon? I'm saying I don't have visibility right now on what we're going to need to staff our system appropriately so that we can see veterans in a timely fashion. Once I know that, once I know what our needs are, I can assure you that I will advocate to assure that we have the necessary resources to hire those physicians.

Mr. O'ROURKE. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Huelskamp, you're recognized for 5 minutes.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

I'd like to follow up on a few questions I asked in my previous round, the first. I appreciate my colleague from Arizona referencing 19 reports. There are also 16 GAO reports, and this is nearly a decade. This is nearly a decade of excuses. I don't know if Dr. Lynch was there, Ms. Mooney was there, Mr. Huff was there. I'm sure he wasn't. He's fairly new, but what I've heard today is there's no accountability for any one of these. We'll throw it on the shelf. Let's start all over again. We'll start all over again. So 35 reports, 10 years later, almost a decade later, we're still here trying to get answers to the same questions asked in 2005. But what I want to ask you today is a question I asked in March 14 of 2013, and I think Dr. Lynch was at that hearing. As far as the issue of accountability and holding your employees responsible for misconduct and gaming the system—that was back in 2005. I requested a list of those who have been punished, censored, and lost their bonuses. That has not been provided. I've been waiting since March 13 of 2013. When can I expect that report from your office?

Dr. LYNCH. Congressman, I don't know where that report is. I would have to defer to Ms. Mooney.

Ms. MOONEY. I'm sorry. What was the date again, sir?

Mr. HUELSKAMP. March 14, 2013. Mr. Schoenhard was before the committee and made reference to gaming the system, and I asked him questions of who would be punished? How would they be treated? Meanwhile, the bonuses continue. Do you realize the information that we have—this is from a Web site source. We can't get it from your agency—but at Phoenix, $843,000 worth of bonuses. That was over a 2-year period. My question, what we haven't received yet, is the listing of those who lost their bonuses for failures in the system. Who are we going to hold accountable? It's easy for you to stand up here, maybe not easy to say, well, the buck kind of stops here or maybe doesn't at all, but the buck stops on who made the decision, the director in Phoenix. Maybe there's one. My question is, when will I get that report answered about what just came out at noon?

Ms. MOONEY. Congressman, I'll work to get an answer to your question.

Mr. HUELSKAMP. How soon will I get an answer, Ms. Mooney? Again, March 14, 2013, still waiting to know how the Secretary of the VA is going to hold employees accountable and responsible for what I think are criminal violations.

Ms. MOONEY. I will work to get that information for you, Congressman.

Mr. HUELSKAMP. Last thing, Mr. Chairman.

I started along this line of questioning trying to identify how many waiting lists are at all VA facilities, and if I understood Dr. Lynch, every facility has a NEAR tracking report? Is that correct, Dr. Lynch?

Dr. LYNCH. Every facility receives a NEAR report, which is the new enrollee appointment request.

Mr. HUELSKAMP. And every VA facility has a schedule and appointment consult as well?

Dr. LYNCH. That may be unique to facilities. That is not probably universal across VA. That is a tool which can be used.

Mr. HUELSKAMP. And the OIG also referenced at the Phoenix VA, screen shot paper printouts, which are not reports, but there were 400 veterans hiding in that system. And, again, to quote the OIG is these veterans, and that's 1,700 folks hidden in these secret waiting lists, that could be at any VA clinic, were and continue to be at risk of being lost or forgotten. As a result, these veterans may never obtain the requested or required primary care appointment. So if I understood correctly from the report and from your testimony is these secret waiting lists could be at every VA facility in the country. Is that correct?

Dr. LYNCH. Congressman, I don't think they were secret.

Mr. HUELSKAMP. How did you not find them?

Dr. LYNCH. I did find them, Congressman.

Mr. HUELSKAMP. How many were on the list? You told me you didn't even look at this list.

Dr. LYNCH. I told you we didn't document the numbers. I told you we were aware of the process.

Mr. HUELSKAMP. Why didn't you report to the press and to Mr. Shinseki and the President of the United States that there were 1,100 veterans waiting for care on that list? Did you tell anybody above you? You waited 35 days, 35 days that you cared for veterans—you said you care about them. They waited on a list languishing.

Dr. LYNCH. Congressman, I was focused on trying to improve the process.

Mr. HUELSKAMP. What about the 1,100 veterans? So you knew these veterans that were waiting for care, primary care——

Dr. LYNCH.—I wish I had identified the numbers of veterans, and we could have moved forward more quickly.

Mr. HUELSKAMP. Did you try to do anything to try to get care for these veterans, 1,100 veterans waiting? Some of them might have been on the list that died?

Dr. LYNCH. Congressman, we identified the processes, and we put people on the ground.

Mr. HUELSKAMP. Yes or no, did you do anything for those 1,100 veterans?

Dr. LYNCH. Congressman, I put in place an understanding of the process which allowed us——

Mr. HUELSKAMP. They are still waiting for care. I think that's your answer.

I yield back, Mr. Chairman.

The CHAIRMAN. Mr. Walz, you are recognized for 5 minutes.

Mr. WALZ. Thank you, Mr. Chairman.

What you're hearing tonight is Members of Congress are doing what they should do; they're channelling the American public. As Mr. Cook said, many of us on Veterans Day, as I'm sure you all did, heard this. It's on people's minds, which shows you their commitment to getting this right is there and finding solutions. And I appreciate that statement, Dr. Lynch, that this is about establishing and maintaining the good parts and the important parts and the critical parts of a world class health care system and trying to reestablish that sense of trust, so they're channeling that.

It's also incumbent upon us to understand how things work, how the system works and understand the positions you're in and

where you're at. I think it's important to point out there's people that failed our veterans horribly. There's people that failed the Secretary in this, as you're hearing. I do think it's important, and I would note, Mr. Huff's not a political appointee. He's a civilian, civil servant, and he's a veteran.

And I'm not certain why you're here, Mr. Huff, and so but I appreciate you coming here. I appreciate you standing and being willing to answer the questions.

I think as we go through this painting with the broad generalized brush, it is not going to be helpful. But this desire to hold accountable, it's not personal in terms of personally trying to damage someone. It's personal about the care for those veterans, and it's personal about this belief if someone cannot be held accountable for such egregious dereliction of their duty, how can we expect for it to get better?

So I hope you're in that. I would ask, and I think the statement that's coming through on this is, yes, we need the data. Yes, we don't need to jump to conclusions. Yes, people deserve due process. Veterans on the list Mr. Huelskamp was talking about and people that are sitting here or elsewhere trying to get that right.

I would suggest or put forward in seeing this, I think one of the things I think we're going to find out in this is that why it's a large system, there are distinct differences inside of VISNs and inside of institutions. I would put forward to you as we went out several weeks ago to the Minneapolis VA, I went with the leaders of our Veterans Service organizations, and as Director Kelly and his staff briefed us, we did the audit you're talking about. They produced the numbers we're talking about. And then I asked them and told them we're going to produce this for the press. And a courageous decision was made by the VISN director to go ahead and release that data and put it out there. And so what you had happen was, that you had this audit, you had the VSOs, who, by the way, hold offices inside that medical center. The legion sits in that office. And so these leaders were there, and you know what else they do? On a weekly basis, they meet with the director. They are the consumer advisory board that meets with the director. So many of them were saying, I don't know and we will still find out, but I don't think we could be surprised. But there was a collaboration and a cooperation. And it was released to the press, and guess what happened? A belief amongst the press and an outpouring of people saying, well, yeah, they're failing on that. Audiology is too long, as you heard them say. People are waiting too long for their hearing aids. Ophthalmology has gotten a little better. Primary care is pretty good here, not so good here. But we had an honest accounting. And you know what the public said was, all right, at least now we know where things are at. Let's find solutions.

By not getting that data, by not having that collaboration, by not having that cooperation, by not pulling in your partners who want to help you, it creates the frustrations you're hearing. So I can't go backing up again. I will not, and will not allow people to paint this system with a generalized brush because I know the high quality of care. I know veterans' lives are depending on it being open, but I also will not sit back and allow you or anyone else to let this sys-

tem disintegrate because we're unwilling to answer some of these questions.

What Mr. Huelskamp asked about the bonuses is not unreasonable at this point. What others are asking on this, and I don't know why, and I get it, everyone deserves their due process, but there's such a desire on this, this ends up looking like you're protecting the bad actors. And it can't be healthy for you. It can't be. And the question that got asked is, I know you're all a team. I'm an enlisted guy. We know where this is going. You're being a team player in this, but they're pulling you down. They're pulling the system down. The bad actors are doing this. We have got to hammer this. We have got to hammer it now. We can't wait this long. We know what's out there.

I just am baffled that some people have not just stood up and said, we were doing it wrong; I'm going. This is the way it is. That's not about a pound of flesh for the sake of firing somebody. It's about that we have got to have some healing. This truth commission, that Mr.—it's almost that way. So it's a statement.

I want to make clear, Mr. Huff, you did not deserve to be treated in that way. None of you do in this case, but it doesn't mean that someone is not going to have to say, yep, it's me. Let's go forward and let's get this.

Because, Dr. Lynch you summed it up; it is too important of a mission to fail.

I yield back.

The CHAIRMAN. Thank you, Dr. Wenstrup, 5 minutes.

Mr. WENSTRUP. I do believe that the VA is better for a lot of things that veterans need. It's a better place for them to be, where they're around those that have similar ailments, similar problems, whether it's reaction from Agent Orange, TBI, PTSD, things like that. I know we have a lot of great providers. I heard an expression for the first time a couple weeks ago, and I think it's probably true: If you've seen one VA, you've seen one VA. And they're all very different. And that's a problem that we have within our system. Dr. Lynch, I know you've been a provider. Have you ever been in private practice?

Dr. LYNCH. I've been in academic practice.

Mr. WENSTRUP. Okay, and that was the same thing I asked Dr. Petzel at one point. We have a lot of people that never have been in private practice, which is a different model, which is driving to see more patients, as we alluded to before, and to do it efficiently, and that you wouldn't let people wait because you need to get them into your practice. That's how you keep your doors open. Dr. Roe referred to either adding a doctor because we know we are already efficient, things like that. And that's what I think we need to look at. And you know, when I got here, I'm a new member and I came. I want to be part of the solution and I met with General Shinseki about three times and offered every time to go into VAs, to go into hospitals, in the ORs, the clinics, and say, how can we do things better? I've been a provider in DOD. It's another government-run system, if you will. And there's a lot of things that have been referred to tonight where you're doing stuff that a physician shouldn't have to be doing because it takes away from actually seeing patients. And, again, it gets to that problem of actually patients

into the door. You know, the IG referred last week to, as we put more money into what we saw as more bureaucracy, not more care being given, that's a problem that we need to address. One of my questions is, are we really looking at physician-driven policies? Are we getting bureaucrats driving the policies or physicians driving the policies?

I have two partners in my private practice, orthopedic surgeons. They go to the VA once, twice a month. And they say, you know, I do two surgeries in the time; in my private practice, I do six to eight. I mean, that's a problem. That's a problem we have got to face, and you're hearing more and more stories like that. So are we letting the physicians drive the policy, or are bureaucrats driving the policies?

Dr. LYNCH. Congressman, I hope we're seeing more physicians in leaderships roles. I made that decision 3 or 4 years ago that I thought it was a good move to get further education, to learn more about management, and to try to be a physician who provides a physician's input into management. I think it is important. I think you make good points. I think our physicians can work more efficiently. I think, in fact, it's much easier to hire support personnel than it is to hire a physician.

Mr. WENSTRUP. Well, exactly, it is and those are your physician extenders and allow you to do more.

Dr. LYNCH. And I don't think we have taken advantage of that model in VA as effectively as we can.

Mr. WENSTRUP. No, and I will tell you. You want to talk about the concern of this committee. There's four doctors on this committee, bipartisan, and we met separately with Dr. Jesse and with Dr. Agarwal to discuss how we're evaluating efficiency. And nowhere in there was it like, well, how many patients on average is a certain specialist seeing in an 8-hour period? Well then what are you measuring? I understand you're looking at quality, and cost, and things like that, but if you're not looking at numbers—so in our private practice, if one doctor is seeing 60 patients in an 8-hour day, and another is seeing 30, we're taking a look at what's going on in that situation and how we can make it better. There's nothing within the system that drives that, and that's one of the things that we have got to change if we're going to provide access to care.

Dr. LYNCH. Part of that new productivity model that Dr. Agarwal may have talked about does involve measuring RVU productivity.

Mr. WENSTRUP. Correct.

Dr. LYNCH. And does involve comparing that against access, so I think we're moving in that direction.

Mr. WENSTRUP. I think so, too. It was a productive meeting. It was off the record where we just had a frank conversation as providers and trying to solve problems. I'll leave it at that. We're going to continue those conversations and hopefully drive things in a better direction.

Dr. LYNCH. I look forward to continuing the discussions. I think we do have a lot to learn from the private sector. I think we can learn and we can make a better system and still preserve VA care for veterans.

Mr. WENSTRUP. I hope so. I wanted to ask one other thing. I was wondering if we can be provided with the legal memo that articu-

lates the reasoning for the general counsel to conclude that withheld documents are privileged. And that memo can be redacted, and we would just like to see some justification or precedent set in this situation. Is that possible to get a legal memo on that?

Ms. MOONEY. I'll take your request to the general counsel, sir.

Mr. WENSTRUP. Please. Thank you. I yield back.

The CHAIRMAN. I think there's an assistant general counsel in the room. Could we get an answer from that individual? There's nobody here from—I'm sorry.

Sir, could you step forward and identify yourself?

Mr. HIPOLIT. Richard Hipolit, deputy general counsel for legal policy.

The CHAIRMAN. Thank you.

Dr. Wenstrup, would you ask your question again?

Mr. WENSTRUP. Could you provide us with a legal memo that articulates the legal reasoning from the general counsel to conclude that withheld documents are privileged, and that memo can be redacted? We would just like to see some justification of precedent here.

Mr. HIPOLIT. Yes, we'll do that.

The CHAIRMAN. And, sir, while you're here, can you find out why Mr. Huff's notes were not delivered to the committee as requested in the subpoena?

Mr. HIPOLIT. Yes, I'll check into that.

The CHAIRMAN. Thank you, sir. Very much.

Ms. Walorski, you're recognized for 5 minutes.

Mrs. WALORSKI. I just have a quick question for Dr. Lynch and Ms. Mooney. Based on the data in the inspector general report, do you believe there's a need for a criminal investigation?

Dr. LYNCH. I think the inspector general will make that recommendation. I believe, based on their findings, they have the ability to initiate a criminal investigation if they think it's appropriate.

Mrs. WALORSKI. And you concur with their findings?

Dr. LYNCH. We work with the IG. I respect their opinions. I respect their reports, and I think if they feel there is criminal case, then we need to respect that judgment and let the process follow through.

Mrs. WALORSKI. And Ms. Mooney?

Ms. MOONEY. I concur with Dr. Lynch.

Mrs. WALORSKI. Thank you.

I yield back my time, Mr. Chairman.

The CHAIRMAN. Mr. Jolly, you're recognized for 5 minutes.

Mr. JOLLY. I want to associate my remarks with those of Mr. Walz. I think you're hearing tonight a frustration of the members here because we do have an Article I authority to ask the questions, but our frustration is rooted in the fact that while we conduct the necessary oversight as part of our Article I responsibility, we continue to hear of a wait list and know that there are wait lists, and we are held accountable for that from our constituents. It's kind of a remarkable process that our constituents hold us responsible for a wait list created by the administration, and that's probably fair because we have to execute our responsibility. We have the privilege of living outside the beltway and working inside the beltway, and so we do hear stories from within our own com-

munity that are personal. We hear of delays in medical care. I had a gold star mom who came up to me Memorial Day; she believes that her son took his life because of a lack of timely mental health care, and that's a real story within our community.

That is the frustration because while we have to provide the oversight and get to the bottom of it, all of this is occurring while there's still a wait list. And so my message is very simple, and I mean it constructively, we need to clear the wait list now. We will get to the bottom of how we got here, but the American people, the people in my community, are more concerned with the fact that a wait list exists than how we got here. And ultimately, that's a responsibility and a fix that we have to rely on the administration for. And we have to rely on the President for his leadership, and I'm asking for his leadership on this. It is not political. When he spoke last week, he spoke of the investigations into how we got here. He spoke of sending Mr. Nabors to Arizona, and all that is right and well, but he didn't speak to clearing the wait list. And on behalf of all of us and on behalf of the administration, I think we need tangible measures to restore the crisis in confidence of the American people right now that's been created by the notion of a wait list, that there's untimely care being provided by the VA. That's the issue that we need to hear addressed.

Dr. Lynch, I'm pleased to hear that there is a plan in place over the next 48 hours to get to the bottom of it, but I think the American people need to know that. And my only question really is this, will you take back to the Secretary and, frankly, to the President of the United States, a plea from this Member of Congress to please hold a second press conference on this issue to talk about how the Department is going to immediately clear the wait list while we then engage in the long-term institutional reforms that are required to ensure this never happens again?

Dr. LYNCH. I can certainly carry that back to the Secretary. I don't know whether I have access to the President, but I think I can get the message across.

I think you've made your point. I think it's an important point. I think we need to get out ahead of this and say that we are doing something about this, that we are aware of it, we do have a process to resolve the problems that we see, and to move forward with a better VA health care system.

Mr. JOLLY. I appreciate that response. And, again, I mean this with the utmost respect. I don't mean this politically. But this does need to go to the President of the United States, and here's why: When he held his press conference, he took credit for having made reforming the VA a top priority when he ran for Senate and again when he ran for President. Last week, in his press conference, he took credit for the reforms of the VA that he was responsible for.

If he's going to take credit for those reforms, he needs to lead on this issue. It's not political. He needs to lead on this issue. I'm asking for his leadership on this issue. And I can tell you, people within my district and I know communities across the country are asking for that leadership. And I, for one, will rally behind him the moment I see it, because it's not a partisan issue.

I yield back. Thank you.

The CHAIRMAN. Thank you.

And the final question, Ms. Brownley, you're recognized, 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. And I want to thank you and the ranking member for putting together this important hearing. I'm sorry that I missed a portion of it. I had an amendment on the floor on veteran treatment courts and was trying to deal with that.

But, you know, I want to echo what Mr. Jolly just said. I think I also—my constituents and my veterans and my community also are saying—they're not so concerned about how we got there right at this moment, but they want to resolve this issue in terms of getting a timely response and making sure that their health care needs, both physical and mental health care needs, are taken care of. We've got to figure out the long-term problems, without question.

I think the one question that I wanted to conclude on is that I'm happy that we're going to do a, sort of, national audit. I want to understand what that includes. Does it include, like, the Oxnard CBOC in my district? Does it go down to that level? And I want to know——

Dr. LYNCH. It is my understanding that the audit has now been extended to all VA health care facilities.

Ms. BROWNLEY. Very good. Very good.

And then, if the VA could provide us with a timeline of every single facility and when this audit is going to take place and when it will be completed and what are the results of that, so that we have a timeline that we can report back to our districts on but that we can also monitor and watch to make sure that we're covering every single facility across the country. Phoenix has brought a lot to our attention, but I'm concerned about so many other facilities across the country.

And if I could get your commitment today that you will provide us with that information, I would be very appreciative.

Dr. LYNCH. I will do my best to get you that information. I think it is available. I think our process has been well-tracked, and I think we should be able to basically show you when each facility was audited and, when the report is finished, to give you information about the audits at each of our facilities.

Ms. BROWNLEY. Thank you very much, and I yield back.

Mr. MICHAUD. Madam, would you yield?

Ms. BROWNLEY. Yes, I would yield.

Mr. MICHAUD. I have a follow-up question that, Mr. Lynch, that you responded to Dr. Roe, as far as performance and metrics. Did I understand you correctly that the different VISNs are the one that do their own performance and how they evaluate?

Dr. LYNCH. The network directors establish the performance measures for the medical center directors. The Deputy Under Secretary for Health for Operations and Management establishes the performance measures for the network directors.

Mr. MICHAUD. Okay. But are they different in different networks?

Dr. LYNCH. I believe the networks—there are some performance measures that are standardized across the system. There is some

flexibility to introduce performance standards that may relate specifically to the network or to the facility.

Mr. MICHAUD. Okay. Yeah, I wish that you would look at that, because what concerns me is, if different networks have different performance measures, I don't know why they would be different.

Because my big concern is, actually, I know when the American Legion went to the Baltimore facility when they were doing the System Worth Saving, they questioned how the Veterans Benefit Administration was dealing with claims at the Baltimore facility. The response that American Legion told me from the staff at the Baltimore facility was, "There is the VA way of doing things, and then there is the Baltimore way of doing things, and we're doing it the Baltimore way of things."

So that is a concern that I have, is even though the Secretary might say, this is the way it is systemwide, you've got different regions doing things differently because that's the way they've always done that. And it gets right back to the metrics, performance measures, and how we hold different regions or employees accountable if it's different in different regions.

And I think that definitely has to be looked at, is what is that performance measures and metrics, and if it's good for one region, why isn't it good for another. So——

Dr. LYNCH. I think regions and facilities may be different. So, in some cases, there may be a necessity to have some flexibility in assigning performance measures based on what you need to achieve at that facility.

Mr. MICHAUD. Okay. Thank you.

And I yield back.

Ms. BROWNLEY. I thought I was supposed to yield back.

Mr. MICHAUD. I yield back to you, Ms. Brownley.

Ms. BROWNLEY. I yield back.

The CHAIRMAN. Do you have any further statements?

Ladies and gentlemen, thank you for being here tonight. Thank you for your interest.

Thank you for appearing. It goes without saying, the subpoena will not be served. Thank you for coming here tonight.

This hearing's adjourned.

[Whereupon, at 11:34 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF JEFF MILLER, CHAIRMAN

I would like to welcome everyone to our hearing tonight where we will discuss VA's continued lack of compliance with the subpoena for documents we issued on May eighth [8th].

First, I would like to ask unanimous consent that Representative Sheila Jackson Lee from the state of Texas be allowed to join us here on the dais tonight.

Hearing no objection, so ordered.

As I am sure many of you are aware, this afternoon the VA Office of Inspector General issued an interim report that confirmed appointment scheduling manipulation, discovered by this Committee, and substantiated that significant delays in access to care have negatively impacted the quality of care at the Phoenix VA Medical Center.

The OIG also indicated that it has expanded its investigation and has opened cases regarding forty-two VA medical facilities nationwide. The OIG clearly found that inappropriate scheduling practices are systemic throughout VA. The OIG's interim findings make it all the more urgent for VA to come clean and fully comply with our subpoena. Veterans' health is at stake, and I will not stand for a department cover-up. Further, to fulfill our congressional oversight duties, it is absolutely essential to receive the documents we request from the VA.

The scope of the May eighth [8th] subpoena was very narrow and was sufficiently tailored to provide a reasonable time to produce the documents in full. The subpoena simply demanded production by may nineteenth of all emails and written correspondence sent and received by certain VA officials between April 9, 2014 and May 8, 2014, regarding the destruction or disappearance of alternate or interim wait lists at the Phoenix VA Medical Center.

My staff was told that the Committee would only be receiving a partial response on the original due date and that VA would produce additional documents on a rolling basis over an indefinite and undefined period of time thereafter.

If this Committee were to acquiesce to VA's unilateral rewriting of the subpoena terms, it would perpetuate VA's belief that selective compliance with Committee requests is acceptable and would allow VA to continue its perceived mission to prevent this Committee from doing its job.

Last night, we received from VA what they purport to be the last of the three sets of documents they have produced to the Committee. The VA has claimed that they searched twenty seven different record custodians and they have produced over fifty-five hundred [5500] pages of documents. At this point, given their pattern of stone-walling Committee requests, I am not at all convinced that they have conducted a thorough and comprehensive search for responsive records.

I know that VA is withholding documents relating to at least three relevant communications by claiming attorney-client privilege. However, VA failed to produce the privilege log demanded by the subpoena, or provide any explanation whatsoever, which is necessary for us to consider whether we will accept the assertion of privilege. This Committee deserves a complete explanation of the interim list document destruction at Phoenix and for its general failure to respond to ongoing requests related to delays in care.

Last week, I invited Ms. Joan Mooney, Dr. Thomas Lynch, and Mr. Michael Huff to explain VA's incomplete record production to the Committee.

They failed to show.

On May 22, we prepared three additional subpoenas for Dr. Lynch, Ms. Mooney, and Mr. Huff to compel them to appear before us this week, if they again decided to decline our invitation to this evening's hearing. We expect VA to be forthcoming, but unfortunately it takes repeated requests and threats of compulsion to get them to even be here today. I look forward to hearing what they have to say.

PREPARED STATEMENT MIKE MICHAUD, RANKING MINORITY MEMBER

Thank you, Mr. Chairman.

Tonight we again find ourselves in a difficult position. I appreciate the witnesses appearing before us this evening, and for the additional production push of materials that came overnight. Unfortunately, those materials, and the release of the interim IG report today, did not provide the answers we sought, but rather, just raised more questions.

Mr. Chairman, I share your frustration. I share your passion for getting to the bottom of this issue. We have been bipartisan on so many things within this Committee. I am hopeful we can continue that, even as this situation gets increasingly difficult and emotionally-charged.

I am not completely satisfied with VA's response to our inquiries and their compliance with the subpoena. However, I do feel, over the past few days, there has been a shift toward increased responsiveness and offers to try and work harder to satisfy our requirements. A key takeaway for me tonight will be hearing the VA respond to our requests for information, and what their reasons are to-date for failing to do so in a timely manner.

Let me be clear. I am not happy with this situation. I am not wholly satisfied with VA's responsiveness. We expect answers. We will get to the bottom of this issue, uncover the truth and ensure a solution is implemented that never allows something like this to happen again.

We expect accountability—full accountability—for every failure that harmed a veteran, and for every individual who perpetrated such harm. I strongly urge the IG to diligently—but swiftly—provide a comprehensive, final report so we can take action and people can be held accountable.

We all share the same goal of ensuring our veterans receive the highest quality care and treatment possible—they deserve nothing less. I believe, as national leaders, we must rise above politics and emotion, and act pragmatically to achieve the best outcomes for veterans. We must take responsible actions that will yield real results, and take care not to politicize our work or this process. I look forward to the opportunity to get some substantive answers from the VA tonight.

With that Mr. Chairman, I yield back.

PREPARED STATEMENT OF HON. CORRINE BROWN

Mr. Chairman and Ranking Member:

On January 16, 2003, in response to an increase in veterans requesting benefits from the VA, the Bush Administration limited the number of veterans who could access the services they earned through their sacrifices.

On June 15, 2009, Secretary Shinseki reversed this order and because of that decision, millions more veterans enrolled in the VA healthcare system.

The Secretary also created numerous presumptions regarding the illnesses Vietnam veterans are suffering. In addition, veterans who suffer from PTSD and TBI were given access to the VA system. This was the right thing to do, even though it also added millions of veterans to the system.

Mr. Chairman, I am surprised at the direction this Committee has taken. The news reports correctly say this is only the second subpoena of the VA in its history. What they don't say is that both have been prompted by the current Chairman.

And today the Chairman called for the resignation of Secretary Shinseki after saying for weeks that he wanted to wait for the Inspector General's complete report to be released. We should keep in mind that the interim report states that "despite the number of allegations, each individual allegation is nothing more than an allegation."

It is incumbent upon us to wait for the evidence before passing judgment. Attacking the people doing this work is not conducive to serving our veterans.

This past Memorial Day weekend, I had the honor to talk to many veterans about the care they are receiving. In Clay, Alachua and Seminole counties; and the cities of Jacksonville and Orlando, I talked to those veterans who have a vested interest in how the VA functions and I didn't talk to one person who was upset by their care.

As the President said recently, those "who have been fighting on the battlefield . . . should not have to fight a bureaucracy at home to get the care that they've earned." I agree and am pleased the VA has brought down the claims backlog by almost half, and is well on its way to being eliminated by the stated goal of 2015.

The VA provides quality and timely healthcare to our veterans. We have a duty to make sure that all those who have defended this country when called upon receive the care they have earned through their service. I support the Secretary in his nation-wide access review and look forward to hearing his report when it is finished.

FOR THE RECORD

STATEMENT FROM: HON. CORRINE BROWN

Today the grandstanding Governor of Florida filed suit against the VA regarding their lack of access to private veterans' health records.

This past Memorial Day weekend, I did my reconnaissance in Florida and had the honor to talk to many veterans about the care they are receiving. Jacksonville; Clay, Alachua and Seminole counties; and Orlando, I talked to those who have a vested interest in how the VA functions. I didn't talk to one person who was upset by their care.

We are in good shape in Florida because of the Oversight of this Committee.

The new clinic in Jacksonville, the wrap-around construction in Gainesville and the new operating rooms in Miami. Hopefully soon, a new hospital in Orlando. We have new cemeteries in Bushnell, West Palm Beach, Jacksonville and Tallahassee.

Our Veterans Affairs Committee, headed by Chairman Jeff Miller, other Oversight Committees in the House and Senate, and the agencies Office of Inspector General are fully capable of providing proper oversight of the Department of Veterans Affairs. The Florida VA treats over 546,874 veterans, and provides healthcare that has consistently been rated in the top 10% nationwide for the care of our veterans.

My message to Governor Scott: I and every Member of Congress are committed to ensuring the proper care of our veterans.

Florida is taking care of its veterans.

LETTER FROM: HON. CORRINE BROWN: TO: HON RICK SCOTT

The Honorable Rick Scott, Governor, State of Florida
The Capitol, 400 S. Monroe St.,
Tallahassee, FL 32399–0001

Dear Governor Scott:

I am writing to express my grave concern that employees of the Florida Agency for Health Care Administration, at your specific direction, have entered and questioned staff at U.S. Department of Veterans Affairs facilities in Florida. Neither you as the Governor, nor any of your state agency personnel, have any authority over our nation's federal agencies or activities. Your failure to acknowledge and respect the separate role of state and federal government is inappropriate, unprecedented, and could be a violation of the law.

Ironically, the same agency you directed to make these unauthorized visits, purportedly out of a concern for the quality of healthcare being provided to our veterans, has failed to provide health services to 900,000 deserving Floridians. Even more troubling, the $55 billion dollars being provided by the federal government to expand Medicaid to uninsured Floridians is made up of taxes Floridians have already sent to Washington. Yet just like the federal funds for high speed rail that were refused by the governor and quickly disbursed to other states, this funding for Medicaid expansion will eventually be accepted by other states who choose to provide health coverage to their residents. Meanwhile, the majority of Florida's nearly one million uninsured citizens would continue to go without insurance.

Additionally, the changes to the Medicaid program instituted through your requested waiver are harming patients care. One stark example is the change to the client transportation system. My office has heard from both local elected officials and providers that patients are not being provided proper transportation, and this inadequate transportation is jeopardizing the safety and health of the Medicaid patients. In fact, my congressional offices have even heard reports of people being dropped off at incorrect addresses, patients being driven by drivers who are unprepared or lack knowledge of their specific health needs, and even cases where patients have been lost and their families subsequently had to file a missing person's report just to locate them—again—because of the disastrous implementation of the transportation portion of your Medicaid waiver program.

This coupled with the continued problems at the Department of Children and Families, including their repeated failure to protect vulnerable children, Enterprise Florida's failure to create jobs or account for funding, the Department of Economic Opportunity's failure to provide jobless benefits for Florida citizens, and the repeated scandals at the Orlando Expressway Authority, make it clear that there are serious oversight issues at your own state agencies.

Our Veterans Affairs Committee, headed by Chairman Jeff Miller, other Oversight Committees in the House and Senate, and the agencies Office of Inspector General are fully capable of providing proper oversight of the Department of Veterans Affairs. The Florida VA treats over 546,874 veterans, and provides healthcare that has consistently been rated in the top 10% nationwide for the care of our veterans. I assure you that I and every Member of Congress are committed to ensuring the proper care of our veterans.

I would recommend that you and the state agencies you oversee focus on the many serious problems facing the citizens of Florida due to the dangerous budget cuts implemented by you and your allies in the state legislature, and your refusal to accept $55 billion in federal funds that would provide health services for the working poor while bringing down overall healthcare cost for the state.

Sincerely,

Hon. Corrine Brown